THE RELATIONSHIP OF DUAL RELATIONSHIP ETHICALITY TO
THERAPEUTIC STRESS, TOLERANCE FOR AMBIGUITY,
PERSONAL BOUNDARY PREFERENCE AND GENDER:
A NATIONAL SURVEY

DISSERTATION

Presented in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy in the
Graduate School of The Ohio State University

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* * * * *

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To My Grandparents

Virgilene Genevieve Eggleston Richardson and Maurice Kenneth Richardson

To my grandmother who sacrificed to give me something she always said “no one could ever take away”; an education. To my grandfather who always has something good to say, taught me to see the lighter side of life, and to not take myself too seriously. And to both of them for instilling in me a belief and a trust in God.
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CHAPTER I
INTRODUCTION

The area of dual relationships has recently emerged as a salient ethical issue for counselors, as well as, other professionals in the human services field. A dual relationship occurs when a counselor "...has other relationships, particularly of an administrative, supervisory, and/or evaluative nature with an individual seeking counseling services..." (AACD, 1988, B. 13.). Therefore, when a counselor assumes more than one role with a current or previously seen client, a dual relationship transpires. This special kind of relationship can be sexual or nonsexual and "affect[s] all counselors and human specialists regardless of their work setting or clientele" (Herlihy & Corey, 1992, p. 3).

According to Pope (1985) three levels of standards are violated in dual relationships: clinical, legal, and ethical. Clinical implications can be drawn from the harm that frequently occurs to clients, supervisees, and/or students from such relationships. Evidence is accumulating in the literature concerning the harmful effects on clients (Williams, 1992). These negative effects include: the inability to trust, feelings of guilt, severe depression, increased anxiety, increased suicidal thoughts, feelings of being coerced and exploited, and difficulty with boundary issues (Glasser & Thorpe, 1986; Pope, 1988).
Legal violations sometimes occur, especially if the dual relationship involves sexual contact. These complaints are typically handled directly by the courts. Clients can file civil and/or criminal suits, since in some states sexual conduct with a client is a felony offense (Hotelling, 1988). As evidenced in the rising complaints being filed against counselors, insurance rates for malpractice have risen dramatically over the last 10 years. Usually ethical complaints are filed before legal redress is sought (Hotelling, 1988). Ethical violations are typically managed by the professional organization to which the member belongs.

In order for a professional organization to be recognized as such, it must develop a code of ethics which serves as a guideline for members delineating professional duties (Allen, 1986; Mabe & Rollin, 1986). The criticism most often directed toward ethical standards set by organizations is that they are general and can not be applied to every situation (Corey, Corey, & Callanan, 1993). The American Counseling Association (ACA), is the most prominent national organization which has developed ethical standards for the counseling profession. According to the Ethical Standards of ACA (AACD, 1988), dual relationships "that might impair the member’s objectivity and professional judgement" are clearly stated as being unethical (Section B. 13.).

Most, if not all, of the helping professions have ethical codes that state sexual conduct with clients is unethical. However, mental health professionals and even the different organizations within the helping professions often disagree about what behaviors to endorse as ethical in regards to nonsexual dual relationships between counselors and clients. Some professionals argue that all of these behaviors always cause harm to clients (Kitchener, 1988), while
others argue that they do not always cause harm and can not be avoided (Corey, Corey, & Callanan, 1993; Keith-Spiegel & Koocher, 1985). Due to these disagreements and accompanying ambiguity in the counseling field about dual relationships, it is difficult for counselors and clients to identify what would be appropriate behavior in certain situations. Recent research based on national samples of mental health providers concur that mental health professionals are unsure of the ethicality of a variety of therapist behaviors (Borys, 1988; Gibson & Pope, 1993; Pope, Tabachnick, & Keith-Spiegel, 1987). In addition, the ACA Ethics Committee (1992) indicated that out of the 45 violations cited by complainants, 24% or nearly 1/4 of the all the violations were related to dual relationships (ACA Ethics Committee, 1992).

Herlihy and Corey (1992) state that dual relationships are pervasive, difficult to recognize in daily practice, sometimes unavoidable, but do not always cause harm. Importantly, dual relationships are problematic because of the power differential between the counselor and the client which is inherent in helping relationships (Edelwich & Brodsky, 1991; Lakin, 1991; Pope & Vasquez, 1991). Counseling relationships are not egalitarian. Clients enter into therapeutic relationships when they are in crisis and emotionally vulnerable. They are the ones sharing personal information which also leaves them exposed. When another role is imposed on the therapeutic relationship, a conflict of interest for the counselor is created and there is a potential to affect his or her ability to maintain objectivity during, or even after the termination of, the therapeutic process. Therefore, the potential for harming or exploiting the client is increased when multiple roles exist (Kitchener, 1988).
Given that mental health professionals report different attitudes about dual relationship behaviors and that these relationships are problematic clinically, legally, and ethically, researchers have investigated several variables which may be related to counselor/client involvements. These variables include: stress (Baer, 1991; Farber, 1983; Farber & Heifetz, 1982), individuation/differentiation (Baer, 1991; Hansen, 1991), differences between professions (Borys, 1988), sex of client (Baer, 1991), sex of therapist (Baer, 1991; Borys, 1988; Holroyd & Brodsky, 1977; Pope, Keith-Spiegel, & Tabachnick, 1986), theoretical orientation (Borys, 1988; Darling; 1991; Pope, Tabachnick, & Keith-Spiegel, 1987), years of experience (Borys, 1988), sexual orientation (Thoreson, Shaughnessy, Heppner and Cook, 1993), and self-report of actual practices of behaviors (Borys & Pope, 1989; Darling, 1991; Pope, et al., 1987).

Stress has been a widely investigated variable in several different disciplines. Typically, researchers from these disciplines agree that stress can be produced by individual, societal, and/or work-related factors (Farber, 1983; Leatz & Stolar, 1993; Smith, 1993). It has been related to substance abuse, depression, occupational burnout, and a myriad of stress related illnesses such as headaches, hypertension, gastrointestinal tract problems, and hypoglycemia (Leatz & Stolar, 1993).

In particular, therapists have been studied with regards to general life stress and therapeutic stress. Associated variables studied have been type of practice setting and type of caseload (Hellman & Morrison, 1987), experience level of therapist (Hellman, Morrison, & Abramowitz, 1987a), burnout, job
performance, and job withdrawal behaviors (Farber & Heifetz, 1982; Lazaro, Shinn, & Robinson, 1984; Raquepaw & Miller, 1989; Ross, Altmaier, & Russell, 1989), as well as, stress experienced in resolving ethical dilemmas (May & Sowa, 1992).

General stressors have been studied in relation to counselor ethical behaviors, however, therapeutic stressors have not. Since dual relationship ethical behaviors are associated with professional duties it is thought that therapeutic stress would be more likely to contribute to endorsement of behaviors than a measure of general life stressors. Therefore, therapeutic stress is included as a variable in this study.

As previously indicated, differentiation is the ability to maintain separateness from others. There is an expectation that certain boundaries are maintained in counseling relationships due to many factors including the intimacy of emotional sharing by the client. Dual relationships are therapeutic boundary issues. Several human service professionals have written on the violation of boundaries in dual relationships (Gabbard, 1991; Olarte, 1991; Pope, 1990a; Wilmer, 1992). In particular, Hansen (1991) investigated psychotherapists’ individuation, boundary/fusion tendencies and endorsements of work related stress. And, Baer (1991) investigated this variable in relation to stress and the endorsement of ethical attitudes and practices.

Work stress and the relationship to ethical behavior endorsements have not been investigated thus far. It is believed that the less able a counselor is to keep boundaries around certain interactions and behaviors, the more the counselor will endorse ethical behaviors. The more boundaries, and the more
stable the boundaries, the less ethical behaviors endorsed. Thus, boundary-
fusion tendencies should contribute to ethical endorsements.

Baer (1991) reported that there may be one or more variables besides
stress that "may intervene concurrently to influence therapists’ attitudes" (p.
123). She suggested that tolerance for ambiguity may be one of those
variables. Therefore, this study investigated the role ambiguity tolerance plays
in influencing counselor endorsement of the ethicality of dual relationship
behaviors. Ambiguity has not been studied previously in regard to the
endorsement of ethical behaviors. It is hypothesized that the less tolerant of
ambiguity a counselor is the less items he or she will endorse as ethical.
Therefore, high tolerance for ambiguity should contribute to the endorsement of
behaviors as ethical.

Gender biases have frequently been reported in the literature regarding
dual relationships and in Ethics Committee reports (AACD Ethics Committee,
1991; ACA Ethics Committee, 1992; American Psychological Association, Ethics
Committee, 1988; American Psychological Association, Ethics Committee, 1991;
Holroyd & Brodsky, 1977; Borys & Pope, 1989). The majority of findings
concerning this variable are summed up well in the study by Pope et al. (1986).
They state that "male therapists were significantly more often attracted to clients
than were female therapists...and that therapists were generally more attracted
to female than male clients" (p. 152). The ACA Ethics Committee report states
that more males are accused of ethical violations and more females are
complainants (AACD Ethics Committee, 1991). However, there are alternative
findings in the literature which have caused professionals to be cautious about
making blanket statements regarding gender and dual relationship behavior (Baer, 1991; Thoreson, et al., 1993). Given the mixed results on this variable, gender of therapist and gender of client were included in the present research to investigate the contribution to the endorsement of ethical behaviors.

In summary, there is further need for research in the area of dual relationships due to: 1) the potential for emotional harm to clients, students, supervisees, and therapists from violations; 2) the proportion of complaints being filed against counselors for dual relationships that have been rising steadily over the years, especially with nonsexual violations; and 3) the ambiguity of the factors related with counselor attitudes towards the ethicity of dual relationship behaviors. In addition, nonsexual ethical behaviors are important to investigate specifically because “there may be an increased risk of a therapy relationship becoming sexualized when there are non-sexual boundary violations during therapy” (Borys, 1988, p. 181). In other words, if researchers can investigate the contribution of variables to the violation of the ethical boundaries by therapists, it may be possible to use the findings to educate and prevent such occurrences.

In particular, this research was designed to investigate the contribution of therapeutic stress, personal boundary tendencies, tolerance for ambiguity, and gender of counselor and client to the endorsement of ethical behaviors. The demographic information of age, marital status, theoretical orientation, sexual orientation, and experience were utilized in this study to compare early to late respondents and respondents to nonrespondents for representativeness of the sample.
Need For The Study

Most research has been conducted on sexual intimacy violations rather than on the nonsexual dual relationship violations, even though the latter seems to be the most confusing to counselors (Pope et al., 1986; Pope et al., 1987; Tabachnick, Keith-Spiegel, & Pope, 1991). From the vast amount of research Pope and his colleagues have produced regarding sexual intimacies between therapists and clients, Pope (1988) has been able to identify the 10 most common aspects existing in these relationships. These 10 aspects constitute, what Pope identifies as the “Therapist-Patient Sex Syndrome” (Pope, 1988). Even with this profile, there is still a great deal of information that is unknown concerning sexual dual relationships.

Only three empirical studies could be located by this researcher which were designed to gather information predominately in the area of nonsexual dual relationships, which is the primary focus of this research. In the first study, Borys (1988) investigated nonsexual dual relationships by developing the Therapeutic Practices Survey (TPS). This instrument was developed for the purpose of collecting information on therapists’ attitudes and practices on differing dual relationship behaviors. She investigated the following variables: theoretical orientation, profession (psychiatrists, psychologists, and social workers), sex of therapist, sex of client, practice setting, region of residence, practice locale, years of experience, marital status, and age (Borys, 1988).

Two studies were generated from the Borys research. First, Darling (1991), investigated dual relationships within small college counseling centers which incorporates a population of several different human service providers
belonging to different professional organizations. She utilized an adapted form of the TPS. Darling (1991) concentrated on the correlations between the attitudes of the ethicality of behaviors and actual self-reported practices. The variables used by Darling were similar to those in Borys' (1988) study. Second, Baer (1991) also used an adapted TPS to investigate the attitudes of ethicality of behaviors. By using suggestions from previous research (Borys & Pope, 1989; Pope & Bouhoutsos, 1986) which called for an investigation of therapist impairment, she added to the original design. In addition to the variables of sex of therapist, sex of client and theoretical orientation, Bear investigated the relationship of differentiation of therapist (the ability to keep clear personal boundaries from clients) and level of general stress to the assessment of ethicality of client involvements. She found mixed findings regarding the differentiation and stress variables. Due to the mixed results regarding the variable of stress and differentiation, Baer (1991) suggested that there may be one or more variables besides stress that "may intervene concurrently to influence therapists' attitudes" (p. 123). Tolerance for ambiguity was suggested as one of those variables.

In summary, the literature suggests that further research is needed to understand which therapist personality variables are related to the attitudes of ethicality (Borys, 1989) and to replicate what has previously been researched. Much of the research has focused mainly on samples of psychologists, social workers, and psychiatrists. The paucity of research on counselors and their ethical attitudes and practices is of great concern (Gibson & Pope, 1993). More systematic research is needed with this population in order to understand how
counselors deal with dual relationships as a profession and the factors which contribute to these violations. Investigation of non-sexual dual relationships is also important given the suggestion in the literature that mental health professionals who violate non-sexual boundaries are at an increased risk for sexualizing therapy (Borys, 1988).

**Significance Of The Study**

This research will provide empirical data which can be utilized to extend the knowledge base in the area of counselor characteristics important to the assessment of nonsexual ethical behaviors. This appears to be the first study which employed a national sample from the ACA specifically designed to investigate the relationship of counselor personality characteristics (measures other than demographic) and attitudes toward nonsexual dual relationships. It is hoped that this will encourage other researchers in the counseling profession to replicate and build upon these findings and fill a void regarding national data on these variables. In addition, this may be the first study designed to investigate the relationship of therapeutic stress (as opposed to general stress) and ambiguity for tolerance in relation to ethical assessment. Last, the findings may also provide guidance and needed information for the revision of the ACA Ethical Standards (AACD, 1988).

**Purpose Of The Study**

The purpose of this study was to examine the 1) endorsement of the ethicality of nonsexual dual relationship behaviors in the counseling population;
2) contribution of therapeutic stress, personal boundary tendencies, tolerance for ambiguity, sex of client, and sex of therapist to the overall endorsement of the ethicality of nonsexual dual relationships; 3) relationship of the independent variables to each of the ethicality subscores. The predictor variables are therapeutic stress, personal boundary tendencies, tolerance for ambiguity, gender of client, and gender of therapist. The criterion variable is counselor endorsement of ethicality.

**Research Questions**

This study was designed to focus on four research questions. Each question is stated below.

1. Are the overall ethical behaviors endorsed by counselors dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender factors?

2. Are the incidental ethical behaviors endorsed by counselors dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender factors?

3. Are the social/financial ethical behaviors endorsed by counselors dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender factors?

4. Are the dual professional relationship ethical behaviors endorsed by counselors dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender factors?
**Definition Of Terms**

This study investigated whether the overall ethical behaviors endorsed by counselors were dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender of counselor and client. The following definition of terms provide reference to the nomenclature most salient to the study of this hypothesis.

**Community Standards** - Standards that vary according to the geographical area in which a person lives or practices counseling. The legal system often takes this aspect of moral standards into consideration when mediating a case.

**Counseling** - "Licensed professional counseling involves rendering to individuals, couples, families, groups, organizations, corporations, institutions, government agencies or the general public a service that integrates a wellness, pathology and multicultural model of human behavior. 'Counseling' ...means assisting client(s) through the counseling relationship, using a combination of mental health and human development principles, methods and techniques, to achieve mental, emotional, physical, social, moral, educational, spiritual and/or career development and adjustment through the lifespan" (Bloom, Gerstein, Tarvydas, Conaster, Davis, Kater, Sherrard, & Esposito, 1990, p. 513).

**Counselor** - A professional counselor "possess at least a master’s degree and is certified or licensed to practice in mental health, rehabilitation, substance abuse, employment, educational and other counseling specialties. Settings for professional counselors include community and mental health centers, hospitals, schools and universities, hospices, government, business,
industry, agencies for older Americans, private practice and other community based organizations" (O'Bryant, 1993, p. 3). For the purpose of this study, the terms counselor, therapist, clinician, and practitioner were used interchangeably.

**Countertransference** - "The intrusive, nontherapeutic personal needs of the counselor/therapist, that if unchecked, distort a therapeutic process and diminish its prospects" (Lakin, 1991, p. 11).

**Dual Relationships** - "Dual relationships occur when professionals assume two roles simultaneously or sequentially with a person seeking help" (Hertlhly & Corey, 1992, p. 3). The ethical endorsement of dual relationship behaviors was measured by the Ethics Survey A and B (ESA & ESB).

**Ethics** - "Ethics is a theoretical examination of morals or morality; overt behavior or conduct might be called 'moral' or moral behavior.... An objective inquiry about behavior" (Van Hoose, & Paradise, 1979, p. 9).

**Ethical Standards/Code of Ethics** - General written guidelines of ethical behavior developed by a professional organization for its members. For the purposes of this research, unless otherwise stated, the ethical guidelines utilized refer to the ACA Ethical Standards (AACC, 1988).

**Gender** - For the purpose of this study gender refers to the biological sex of an individual. This was studied by the use of two variables: sex of counselor and sex of client. Sex of counselor was taken from item 1 on the Demographic Information Questionnaire (DIQ). Sex of client was randomly assigned to counselors through the Ethics Survey A (ESA; female clients) and B (ESB; male clients).
**Morals** - "An evaluation of actions on the basis of some broader cultural context or religious standard" (Corey, Corey, & Callanan, 1993, p.3).

**Moral Development** - Ethical reasoning progressing toward increasingly abstract and complex levels of decision making (Foltz, Kirby & Paradise, 1989).

**Personal Boundary Tendencies** - This consists of two dimensions. The boundary dimension is the degree of distance between self and the social environment. This includes time and space boundaries. The fusion dimension is the tendency to blur or merge self with others or the environment. It includes unusual experiences in thinking and unrealistic overconnections with people in their environment (Miller, 1970). Personal boundary tendencies were measured by the Personal Characteristics Questionnaire (PCQ; Miller, 1970) which has two factors; boundary and fusion.

**Therapeutic Stress** - Stress that is occupationally related to being a counselor/therapist. In this research it was measured by the Therapeutic Stresses Rating Scale (TSRS; Hellman, Morrison, & Abromowitz, 1986) which has five subscales: Therapeutic Relationship, Scheduling Difficulties, Professional Doubt, Work Overinvolvement, and Personal Depletion.

**Transference** - "...Attitudes, impulses, and behaviors irrationally and unjustly attributed to the counselor/therapist by a client" (Lakin, 1991, p.11).

**Tolerance for Ambiguity** - "...Willingness to accept a state of affairs capable of alternative interpretations, or of alternative outcomes: e.g., feeling comfortable (or at least not feeling uncomfortable) when faced by a complex social issue in which opposed principles are intermingled" (English and English,
1958, p.24). This variable was measured by the Ambiguity Tolerance Scale (AP-20; Mac Donald, 1970).

**Values** - "...All human conduct in which significant alternatives are available. A choice must exist, and we choose one mode of behavior as preferable or better when compared with other alternatives. Values are 'hierarchically integrated; that is they are related in respect to a greater or lesser degree of desirability' (Van Hoose & Paradise, 1979, p. 19).

**Limitations**

There are factors that may influence the results and generalizability of this study. First, this study is descriptive and not designed to establish causality of behaviors. Second, due to the reliance of self-report instruments, bias may be introduced by the respondents' understanding of the directions and willingness to report honest answers given the sensitive nature of the study. Third, this sample cannot be generalized to all members of the American Counseling Association (ACA) due to the sampling process which excluded members who were students, retired, or emeritus and working with nonadult populations. Fourth, reliable and systematically collected data have not been gathered by ACA or other researchers regarding ACA members, therefore, it is not possible to compare information gathered on research participants in the present study to those of the ACA member population.

In addition, four limitations became apparent after the research data were collected. First, the reliability of the AT-20 and the boundary factor on the PCQ were lower than anticipated. This may have slightly weakened the correlation
matrix coefficients. Second, caution needs to be exercised in the interpretation of the second canonical variate due to sample size (n = 273) which may be insufficient for reliable results (Stevens, 1992). Third, the demographic variables were utilized for comparison of the early and late respondents and of the respondents and individuals only answering the DIQ. These variables were not entered into the multivariate analyses because they had been previously studied with other populations. It was also necessary to hold the number of variables in the canonical analysis to a reasonable size. This decision limited the findings regarding those variables. Fourth, the boundary and fusion variables should be interpreted cautiously due to a lack of clarity in the meaning of the factors. For example, it is important to clarify if the factors are indeed separate (orthogonally rotated) factors or are they on a continuum? If they are separate factors, then what would it mean for a person to have both a high score on boundary and a high score on fusion?

**Summary**

This chapter contains an introduction to the ethical dilemmas surrounding dual relationships, as well as, the need, significance, and purpose of the present study. In addition, research questions, definition of terms, and limitations of the present study are also presented.

The following chapter provides a review of the literature relating to the principal hypothesis. Chapter III addresses the methodology utilized and research results are reported in Chapter IV. The last chapter, Chapter V,
presents a summary of the present study and of the findings, conclusions by revised research questions, and recommendations for future research.
CHAPTER II

REVIEW OF LITERATURE

This chapter is divided into nine sections. It begins with an historical overview of ethics and then presents a model of ethical decision making utilized as a basis for this research. The third section consists of six parts: ethical codes, fundamental therapeutic conditions, definitions, prevalence, sexual and nonsexual dual relationships. Next, in sections four through seven, each major variable is discussed. In addition, section eight addresses each demographic variable. Last, a summary is provided.

**Historical Overview Of Ethics**

The helping professions are still asking several of the same questions as the ancient Greeks and Romans. For example, professionals still ponder how memory functions, learning occurs, and certain diseases are manifested and cured (Hothersall, 1984). In addition, an area that has been fervently debated, among ancient and current professionals alike, is that of ethics.

The root of ethics can be traced to Hippocrates who was born around 460 B.C. He has been considered the founder of medicine and could also be considered the ancient founder of psychology because he “presented the first clear descriptions of many behavioral problems, and formulated long-lasting
theories of temperament and motivation” (Hthersall, 1984, p.6). Hippocrates also expressed concern that physicians should not do harm to those seeking help; the contemporary dictum states "above all else, do no harm” (Dyer, 1988; Pepper, 1991, p.63). This is still one of the most important underlying ethical principles in counseling and psychology today (Kitchener, 1984). Plato, Wundt, Mill, and Kant, as well as more recent philosophers and psychologists such as Durkheim, Piaget, and Kohlberg, have continued to broadened the field of ethical dialogue (Drane, 1982; Hogan, 1973; Rosenbaum, 1982).

However, ethics surrounding therapeutic relationships and the counseling of clients has been a rather recent phenomenon, considering that psychoanalysis was conceived by Freud during the early 1900’s (Arlow, 1984). Even at the conception of formalized counseling, ethical concerns of dual relationships were contemplated. Fenichel, who has written extensively on Freud’s theory of psychoanalysis, stated that "any analyst will do well to avoid analyzing relatives, friends, or acquaintances” (1945, p. 580). However, even Freud believed this was a gray area of ethics stating that "certainly no analyst would refuse his help to persons for whom no other help is accessible; he has only to know that in doing so he takes the risk of losing his friends” (Fenichel, 1945, p. 580). With the conception of new counseling theories over the last 50 years, the field of ethics has become increasing complex. To deal with this complexity most professions have established ethical guidelines to assist members in awareness of issues and to regulate adherence to the ethical codes (Corey, Corey, & Callanan, 1993).
Ethical Decision Making Model

This section contains a discussion of an ethical decision making model which, along with the ethical codes, provides the underlying foundation for the present study. The Kitchener (1984) model which is utilized in counseling and psychology, integrates two fields: philosophy and bio-medicine. Fine and Ulrich (1988) state that "ethics is generally considered the appropriate subject matter of philosophy, insofar as psychologists typically treat ethics as a tool to assist them in conducting their clinical activities, but not as a primary subject matter in itself" (p. 543). Bio-medicine has become increasingly immersed in unprecedented ethical debates and life-death decisions due to the vast expansion of technology (Dyer, 1988).

Ethical decision making models are essential when ethical dilemmas occur. This is particularly true when professional ethical codes are silent about certain areas of conduct or when an individual is a member in more than one professional organization and is faced with conflicting codes.

Kitchener (1984) posits that there are two levels of moral reasoning: intuitive and critical-evaluative. The first level of moral reasoning, the intuitive level, is "based on the sum of their [individuals] prior ethical knowledge and experience" (Kitchener, 1984, p. 44). For counselors, this knowledge would include any coursework in ethics or reflections on the ethical codes. In other words, there are certain situations in which individuals make moral decisions without engaging in a lengthy thinking/reasoning process. They reflect on their feelings about an issue and make ethical decisions based on their development of ethical beliefs over time, and their level of moral reasoning development. In
some instances the reasoning process may have previously taken place, in others, it may be an immediate "intuitive" decision. Beauchamp and Childress (1979) refer to these intuitive decisions as ordinary moral judgement.

The intuitive level of moral reasoning is similar to what others in the field label as moral values (Kitchener, 1984). Kitchener (1984) indicates that this level is not enough to guide professionals through all of the ethical dilemmas that occur in a counseling practice. "One has only to review the ethical complaints against psychologists...to document the fact that not all individuals have moral intuitions that lead them to defensible ethical choices" (Kitchener, 1984, p. 44). Therefore, it is often imperative for another level of moral reasoning to be utilized.

The second, higher level of reasoning posited by Kitchener (1984) is the critical-evaluative level. This level consists of three hierarchically arranged tiers which begins with professional codes, moves to more abstract and general ethical principles, and finally to ethical theory for justification of behaviors.

When immediate judgements are not sufficient in solving ethical dilemmas and further reasoning is necessary, helping professionals often turn to their professional organizations and their specific ethical codes for guidance. Some professional organizations also publish casebooks which are intended to help professionals by offering guidance on ethical issues through the publishing of cases similar to those reported to the ethics committee for adjudication (cf. APA, 1987) and/or by providing cases to "clarify the meaning and intent of each of the standards" (Herlihy & Golden, 1990, p. ix). Sometimes, rereading the code may clarify the ethical concerns and resolve the dilemma, however, there
are many instances where the code is silent, conflicting, or ambiguous (Drane, 1982; Kitchener, 1984; Corey, Corey & Callanan, 1993).

In the cases where the ethical codes are nonconclusive, the professional must rely on the next higher level of justification. In this model, the next tier entails referral to five ethical principles: Autonomy, nonmaleficence, beneficence, justice, and fidelity (cf. Beauchamp & Childress, 1979). These ethical principles provide the foundation for professional ethical codes (Drane, 1982; Kitchener, 1984).

The first principle, autonomy, refers to individual rights and freedoms. Kitchener (1984) indicates that individuals have "both freedom of action (i.e., freedom to do what one wants to do with one's own life as long as it does not interfere with similar freedoms of others) and freedom of choice (i.e., freedom to make one's own judgements)" (p. 46). In counseling, issues such as involuntary hospitalization, informed consent and confidentiality (and the restrictions thereof [e.g., the Tarasoff decision, 1974]) are based in the principle of autonomy.

Nonmaleficence is usually considered the most important and basic ethical principle which states "above all do no harm" (Kitchener, 1984). An individual is precluded from harming others intentionally or engaging in actions that would pose risks to others (Kitchener, 1984). Diagnosis, research, assessment, hospitalization, as well as, clinical issues have a basis in the principle of nonmaleficence. Even so, counseling ethical codes tend to be less explicit about nonmaleficence. Kitchener (1984) states that "nowhere does the code identify what constitutes harm to clients or under what circumstances
harm to clients is justifiable...since harm is an ambiguous term, there will always be a grey area surrounding its definition" (p.48, 49). Codes in the area of research tend to be more specific with regards to how harm occurs as opposed to codes in clinical areas where harm is not really defined (Kitchener, 1984).

The third principle is beneficence and provides for the promotion of good. Counselors are obligated by code (B.1) to "respect the integrity and promote the welfare of the client(s)" (AACD, 1988). Most codes include statements about promoting growth in clients and looking out for the good of the client. Generally, this principle must be balanced against the principle of nonmaleficence.

The fourth principle is justice and states that all individuals must be treated equally unless there is some overriding reason for not doing so (Rawls, 1971). "Anyone - regardless of age, sex, race, ethnicity, disability, socio-economic status, cultural background, religion, or lifestyle - is entitled to equal access to mental-health services" (Corey, Corey, & Callanan, 1993, p. 9). This principle underlies such issues as how it is decided who will receive community mental health treatment and whether the justification is fair.

Last, the principle of fidelity. Loyalty and trustworthiness in counseling are basic to the helping relationship. This principle underlies such issues as confidentiality, the contractual agreements between counselor and client, and informed consent.

Kitchener (1984) indicates that these principles are "prima facie valid (i.e., moral principles are neither absolute nor relative, but they are always ethically
relevant and can be overturned only when there are stronger ethical obligations)" (p.52). There is danger in building a hierarchy of principles in which there is only one order and that order is always followed no matter what the ethical dilemma (Dyer, 1988). This may in and of itself lead to unethical decisions. Instead, the circumstances usually determine which principle may override another given the conflicts of that particular issue.

"Principles are more stable than rules, and yet there are situations in which they too come into conflict" (Drane, 1982, p. 34). It is for this reason that ethical theory is the last justification for moral reasoning. Theories are even more broad than principles and entail a basic level of belief (Drane, 1982).

There are two traditional theories that have been linked with counseling, although, they are certainly not the only theories that could be utilized for justification. Utilitarianism, conceptualized by John Stuart Mill, suggests that "the right action is that which produces the best consequences" (Drane, 1982, p. 42). In other words, an individual weighs the alternatives by the consequences of each and then decides that what ever benefits or is the greatest good for the vast number of people is the right choice (Carroll, Schneider, & Wesley, 1985; Tymchuk, 1986).

The second theory, deontology, developed by Kant, suggests that the consequences are not important to the ethical decision of right or wrong. The act itself determines the rightness. In other words, there are certain values that are held right no matter what the consequences. Therefore, what is good for one person to do should be equally good for all people to do. Every action should be universalized (Carroll, Schneider, & Wesley, 1985).
Both of these theories are represented in counseling and other helping professions' ethical codes. However, most counseling ethical decisions are made in a utilitarian manner. For example, Corey, Corey, & Callanan (1993) recommend the following steps to making ethical decisions: Identify the problem, identify the issues involved, review relevant ethical codes, obtain consultation, consider courses of action, enumerate the consequences of various decisions, and decide on the best course of action. The last two steps in this list are based in utilitarian theory.

Ethical decision making models do not typically include sources of variability such as personal and professional characteristics of counselors. However, Keith-Spiegel and Koocher (1985) do mention that there are situations where variability does occur and research in the field concurs. Haas, Malouf, and Mayerson (1988) found that theoretical orientation, sex, and years of experience significantly influenced choices to certain ethical responses. Kimmel (1991) also found significant differences regarding biases in ethical decision making regarding human subject research. There were significant differences in years of experience since terminal degree, area of degree, sex, and number of APA affiliations.

**Dual Relationships**

This section has been divided into six parts related specifically to dual relationships. The first part, ethical codes, provides a description of the ACA Ethical Standards (AACD, 1988) which specifically relate to dual relationships. It also provides a history of the development of these codes through three
revisions. Second, there is a focus on the fundamental therapeutic conditions that are necessary for counseling to be effective and how dual relationships can intervene with these conditions. Third, definitions of dual relationships are based on the literature. In the fourth part, the prevalence of dual relationships is discussed. The last two parts, contain a review of the literature relating to sexual and nonsexual dual relationships in counseling.

**Ethical Codes**

Ethical codes serve as guidelines for the work a counselor performs on a daily basis. These guidelines are not specific enough to cover all situations that a counselor will encounter, but they do provide guidance and set a manner by which counselors generate their ethical decisions. Ethical principles and theories provide the foundation for reasoning underlying the codes.

Professional organizations have developed ethical codes to: protect the safety of the client/consumer, provide a framework for professional behavior, delineate the responsibility of members, and provide a means to internally regulate member conduct from within the profession (Baldick, 1990; Mabe & Rollin, 1986). There are several professional organizations which publish ethical codes for helping professionals such as: the American Counseling Association (ACA), American Psychological Association (APA), the American Psychiatric Association, the National Association of Social Workers (NASW), the American Association for Marriage and Family Therapy (AAMFT), the National Board for Certified Counselors (NBCC), and the American College Personnel Association (ACPA).
The American Counseling Association (ACA) [formerly known as the American Association for Counseling and Development (AACD), and originally named the American Personnel and Guidance Association (APGA)], established the Ethical Practices Committee in 1953, one year after the organization was formed (Allen, 1986). The Ethical Standards for APGA were "originally established through a collaboration with the American Psychological Association [APA]" (Allen, 1986, p. 293). The ACA Ethical Standards presuppose the ethical principles that were utilized as a foundation for the codes, whereas, the APA Ethical Principles of Psychologists and Code of Conduct (1992) begins the preamble with a specific list and discussion of the underlying principles. The APGA Ethical Standards were approved in 1961 and have been revised in 1974, 1981, and 1988. The draft of the new revision, to be adopted in 1995 or 1996, has recently been sent to members for discussion. The ACA includes 16 divisions, five of which have developed and adopted supplemental ethical standards with regard to the division specialty.

Each revision of the Ethical Standards has become more explicit regarding dual relationship behaviors. In the 1961 document, there was only one code which referred to possible dual relationship problems; Section B.5. This states:

B.5. The member reserves the right to consult with any other professionally competent person about his counselee client [sic]. In choosing his professional consultant the member must avoid placing the consultant in a conflict of interest situation, i.e., the consultant must be free of any other obligatory relation to the
member's client that would preclude the consultant being a proper party to the member's effort to help the counselee or client.

Thirteen years later, in the 1974 revision of the code, there were five references to dual relationships. Section A.2 was changed from the member having "responsibility to the institution within which he serves" (APGA, 1961) to the member having "responsibility both to the individual who is served and to the institution within which the service is performed" (APGA, 1974). In the 1961 code, the member clearly had responsibility to the institution and not to the client, however, in the 1974 revision, the counselor had responsibility to the client and institution. In some instances, this could result in a conflict of interest (i.e., to whom is the counselor loyal?). The second reference to dual relationships is in A.6. This refers to establishing fees and the role of bartering. "Members are willing to provide some services for which they receive little or no financial remuneration, or remuneration in food, lodging, and materials" (APGA, 1974). Bartering was considered an acceptable practice.

The code (B.5) dealing with dual relationships during consultation in the 1961 version was also carried over to the 1974 code (now B.9). Even though the wording changed slightly, the meaning remained the same as stated above.

The first reference to dual relationships within a counseling relationship was added in the 1974 revision; code B.12. It states:

When the member has other relationships, particularly of an administrative, supervisory, and/or evaluative nature, with an individual seeking counseling services, the member should not serve as the counselor but should refer the individual to another
professional. Only in instances where such an alternative is unavailable and where the individual's condition definitely warrants counseling intervention should the member enter into and/or maintain a counseling relationship. (APGA, 1974)

In other words, if a member already had a relationship with an individual, the member should not enter into a counseling relationship with that individual and should refer unless it could not be otherwise be avoided. Here, the circumstances under which a member would enter into a counseling relationship is left to interpretation.

The last code in the 1974 version to deal with dual relationships is similar to B.12 except it is stated from an instructional/training viewpoint. Code G.12 states that "when the training program offers a growth experience with an emphasis on self-disclosure or other relatively intimate or personal involvement, the member should have no administrative, supervisory, or evaluative authority regarding the participant" (APGA, 1974). Dual relationships occur when students are counseled by faculty or supervisors. They also occur when faculty or supervisors function in other simultaneous roles such as mentors and researchers. It is recommended that the student seek personal growth experiences with someone not in an evaluative position (Stadler, 1986).

Three codes remained unchanged in the 1981 revision of the Ethical Standards: A.2 (responsibility to individual and institution), B.9 (consultation), and H.12 (G.12 in the 1974 revision, supervisory and training practices). Three codes were modified or added in the 1981 revision. First, in code A.5 (A.6 in 1974 code, establishment of fees), bartering was deleted. Instead of bartering
for services, members are instructed to help the client find "comparable services of acceptable cost" (AACD, 1981). There was no ruling on bartering by the Ethics Committee, per se, in fact, the word "bartering" was not mentioned in this code. Second, a code was added that forms the basis for monitoring the development of most dual relationships; A.8. It states: "In the counseling relationship the counselor is aware of the intimacy of the relationship and maintains respect for the client and avoids engaging in activities that seek to meet the counselor's personal needs at the expense of that client" (AACD, 1981). Third, added to code B.11 (B.12 in the 1974 code) is the first statement directly addressing dual relationships. The addition states: "Dual relationships with clients that might impair the member's objectivity and professional judgement (e.g., as with close friends or relatives, sexual intimacies with any client) must be avoided and/or the counseling relationship terminated through referral to another competent professional" (AACD, 1981). Twenty years after the first version of the Ethical Standards there is a statement explicitly relating to sexual intimacies and other dual relationships with clients.

In the 1988 revision, which is the current adopted revision, the ACA delineates eight areas in the Ethical Standards (1988): Section A: General; Section B: Counseling Relationship; Section C: Measurement and Evaluation; Section D: Research and Publication; Section E: Consulting; Section F: Private Practice; Section G: Personnel Administration, and; Section H: Preparation Standards. Three of these sections contain ethical codes regarding dual relationships with clients (Appendix K). This revision is slightly more explicit in the area of dual relationships than that of the 1981 revision.
Sections A.2, A.8, B.11 (B.9 in 1981 revision), B.13 (B.11 in 1981 revision), and H.12 are the same as stated in the 1981 revision of the Ethical Standards. Two codes give more explicit guidance than previous versions. One is B.14 which states: "The member will avoid any type of sexual intimacies with clients. Sexual relationships with clients are unethical" (AACD, 1988). Allen, Sampson, and Herlihy (1988) state that "in the 1981 AACD Ethical Standards, the structure to avoid sexual intimacies with clients existed only as a parenthetical example of inappropriate dual relationships under old Standard B. 11" (p. 158). Now, given the knowledge about potential harm to clients the statement is clearly declared unethical (Allen, Sampson, & Herlihy, 1988). The second code change is in H.13. This indicates that students must be given an alternative to participating in growth experiences where they would have to share about their personal self. The affixed component states that "they have a right to accept these alternatives without prejudice or penalty" (AACD, 1988).

This brief chronicle of the Ethical Standards development regarding the attention to dual relationships begins to illustrate how the importance and the seriousness of this issue has expanded throughout the organizations' history. What began with one entry, in 1961, has developed to seven, in 1988, as well as, other modifications (such as the wording about bartering being removed).

It is important to note that besides the benefits of codes such as providing guidance and clarifying professional responsibility, there are also limitations. Some limitations of the codes tend to leave room for dilemmas to arise. Mabe and Rollin (1986) list and discuss six problems or limitations with using a code: codes can not deal with all issues; codes are difficult to enforce;
codes do not state the interest of the client or research participant; sometimes one organizations' codes conflict with another or they may conflict within the same document; codes are a usually reactive not proactive, and; codes may be interpreted differently by each board or by the courts.

An ethics committee within each professional organization generally assists with problems that occur with the codes. The ACA Ethics Committee provides interpretations and opinions on codes, revises and updates codes, processes complaints, and enacts sanctions against members (Allen, 1986).

**Fundamental Therapeutic Conditions**

All therapeutic relationships contain the same basic features regardless of the therapists' major discipline (i.e., counseling or psychology), the theoretical orientation utilized (i.e., psychodynamic, systems, cognitive, behavioral), or the provider (i.e., counselor, psychologist, or psychiatrist) (Kanfer & Goldstein, 1986). Therapeutic relationships are integral to dual relationships, in that dual relationships occur when a counselor has more than one role with a client either during or after the termination of counseling/therapy.

Kanfer and Goldstein (1986) list four features of therapeutic relationships. First, they are unilateral. The client comes to counseling for help and the counselor is designated the helper. A helping relationship is one-sided with the focus upon the client and therapy goals (Kanfer & Goldstein, 1986). Second, the relationship is systematic which means that goals and objectives to solving the clients' problems are established and reevaluated during the course of
counseling. The goals and objectives are usually based upon the theoretical orientation of the counselor. Third, the relationship is formal. There are specific boundaries maintained in the relationship such as the meeting room, time of appointment, arrangement of fees, and contacts outside of the session time. Fourth, the relationship is time limited. When the client reaches his/her goal(s), counseling/therapy is terminated and the relationship ends. Some counselors/therapists do offer the client the ability to return should other problems arise but the counseling/therapy process would remain the same as stated above. When these four features are not maintained, ethical dilemmas may occur. Dual relationships begin by the disregarding of one or more of these features.

Within the therapeutic relationship structural features, certain core conditions are necessary for client growth to occur. Rogers (1957) indicates that the counselor must exhibit genuineness, unconditional positive regard, and empathy. The client must present with a problem, feel anxious about resolving it, and believe in the counselor’s concern for her/him. Together, these conditions constitute the two major inherent responsibilities in the counseling relationship: trust and power (George & Cristani, 1986; Pope & Vasquez, 1991). These conditions are also what can make dual relationships so harmful.

Trust is vested in counselors because of their very role. “In return for assuming a role in which the safety, welfare, and ultimate benefit of clients is to be held as a ‘sacred trust,’ therapists are entitled to the privileges and power due professionals” (Pope & Vasquez, 1991, p. 35). Clients must be vulnerable and trust the therapist with their feelings and anxieties in order to fully explore
them (George & Cristani, 1986). Confidentiality and privilege are attempts to maintain clients’ assurance that the trust will not be violated, however, there are ethical and legal breaches of confidentiality (e.g., harm to self or others). Once trust is violated the therapeutic relationship is not the same and may have to be terminated.

Power is bestowed upon the therapist largely because of the nonegalitarian relationship between him/her and the client (Lakin, 1991). Clients are in a vulnerable state when they enter counseling and therapy and are trusting the therapist to help them. By virtue of their occupation, therapists are privileged to hear information that individuals would not ordinarily share. This information also gives them power over clients.

Pope and Vasquez (1991) suggest four other ways power is derived in the therapeutic relationship. Therapists are sometimes put into positions of referring clients for hospitalization (competency hearings) or they may provide expert testimony in a court of law (Pope & Vasquez, 1991). Therapists also derive power from their knowledge of human behavior and how to promote change in clients (Elderwich & Brodsky, 1991). Lastly, managing transference, the act of transferring attitudes, feelings, and impulses to the therapist by the client (Lakin, 1991), affords the therapist immense power. There are legitimate and illegitimate uses of power that a clinician can use in therapy (Elderwich & Brodsky, 1991).

Counselors have the responsibility to not abuse the power inherent in the therapeutic relationship. Several practitioners have written about the dangers of counseling and psychotherapy as a profession (Freud, 1937; Freudenberger &
Robbins, 1979; Goldberg, 1986; Lanning, 1992). Goldberg states that there are "some careers, which are, at times, downright dangerous. The practice of psychotherapy is one" (p. 25). Lanning (1992), in an article regarding ethical decision making, indicates that "the most difficult part of being a professional counselor is having to make decisions when we will be responsible for the consequences. That is a lonely task" (p.21). In other words, it does not matter how many professionals are consulted in resolving ethical dilemmas, because the final decision rests with the counselor. The decision the counselor makes is hers/his alone and he/she must be responsible for the consequences.

**Definitions**

Pope and Vasquez (1991) state that "dual relationships are relatively easy to define; they are much more difficult to recognize in our practice" (p.112). Virtually no human service professional is immune to dual relationship issues if she/he is providing counseling services (Corey, Corey & Callanan, 1993). Counselors are in a unique position to not only concern themselves with the ethical and legal implications of dual relationships but there also needs to be concern about the therapeutic implications. For example, it may be ethical and legal to hug a client but a counselor must also ask "What implications will this have on the therapeutic relationship?"

Presented here are three definitions of dual relationships, from five of the most prominent writers in the counseling field. First, Kitchener (1988) states that a dual role relationship occurs when "one individual is simultaneously or sequentially participating in two role categories that conflict or compete"
(p. 218). Second, Pope and Vasquez (1991) indicate that a dual relationship "occurs when the therapist is in another, significantly different relationship with one of his or her patients" (p. 112). And third, Herlihy and Corey (1992) consider a dual relationship occurring "when professionals assume two roles simultaneously or sequentially with a person seeking help" (p. 1). All agree that dual relationships can be of a sexual or nonsexual nature and may be concurrent or sequential.

Two of these three definitions directly mention the language of role conflict. Kitchener (1988, 1992) is the only one who has associated role conflict theory with dual relationships. She indicates that inherent in the role of the professional are obligations, expectations, and rights and privileges. Therefore, it is the role conflict that arises from these factors that may threaten the professionals' most fundamental role which calls for maintaining objectivity and placing the client's welfare above their own (Kitchener, 1988). Kitchener and Harding (1990) report that the more the roles conflict on these three factors (obligations, expectations, and rights and privileges), the more potential for harm to the client.

In the literature, dual relationships have been separated into two major areas: sexual and nonsexual. Sexual intimacies are prohibited in most, if not all professional ethical codes. ACA code B.14 regards sexual intimacies to be unethical (AACD, 1988; see Appendix L). Nonsexual dual relationships, code B.13, are considered unethical if they "impair the member's objectivity and professional judgement" (AACD, 1988; see Appendix L). Bates and Brodsky (1989) indicate that there is difficulty with the codes (ACA and APA) due to the
lack of a definition for sexual intimacy. As long as this is undefined, professionals will use their own perceptions regarding the type and degree of intimacy that is acceptable in counseling relationships. Unfortunately, that perception may not lead to ethical decisions. They suggest four factors be considered in the definition of sexual intimacy: the intent of the therapists actions, their judgement in choosing approaches with clients, whether the therapy is moving away from having a one-dimensional focus (on the client), and whether the therapist is treating clients selectively "on the basis of age, sex, and attractiveness" (Bates & Brodsky, 1989, p. 134).

Prevalence

A review of ACA and APA Ethics Committee reports on complaints that have been received, provides an indication of the prevalence of dual relationships. The APA Ethics Committee reported in 1987 that dual relationship complaints for the years 1982 through 1986 were significantly higher than any other complaint area. In 1993, the APA Ethics Committee reported that the "overall category 'dual relationship' continues to be the most frequent primary reason for complaints being filed; it was cited in 28% of cases opened in 1990, 19% in 1991, and 32% in 1992. After adding the multiple categories per case, the percentages increase to 43%, 41%, and 48% of the cases, respectively" (APA, 1993, p. 814). This is the first report (APA Ethics Committee, 1993) where dual relationships were divided into separate categories: sexual misconduct, adult; sexual misconduct, minor; sexual harassment, and; nonsexual dual relationship. "Of all cases involving dual relationship, 23% were
nonsexual for 1990 and 48% and 33% for 1991 and 1992, respectively" (APA Ethics Committee, 1993, p. 814). The total number of cases reported to the Ethics Committee has risen each year, except for a small drop in 1990. The total number of cases reported in 1992 was 358 (APA Ethics Committee, 1993).

The first Ethics Committee report for ACA (AACD) was published in 1991 for the years 1989 through 1991. Apparently, no historical records are available, therefore, comparison of data to previous years can not be made (AACD Ethics Committee, 1991). The ACA Ethics Committee received 11 complaints for 1989-1990 and 18 for 1990 and 1991. Ten cases, five each year, were pursued as formal complaints. Out of the violations cited by complainants, 50% in 1989 and 43% in 1990 were dual relationship complaints.

The ACA Ethics Committee report for 1992 included a total of 19 complaints and 26 inquires. The complaints cited 24%, almost one-fourth, involving dual relationship involvement. Nonsexual dual relationship violations were nearly 18% of the total violations cited by complainants (ACA Ethics Committee, 1992). Findings from a recent national survey of counselor state licensing boards seem to coincide with these reports. Neukrug, Healy, and Heatherly (1992) collected, from 22 states, the number and type of ethical complaints received since the Boards became functional. Sexual dual relationships with clients was the second highest complaint area; 20% of the total number. Nonsexual dual relationships (not defined) constituted another 7% of the total complaints.

The ACA and APA Ethics Committees report that complaints are increasing every year. However, in a national study, Borys and Pope (1989)
found no difference in the rates psychiatrists, psychologists, and clinical social workers reported engaging in sexual intimacies with clients. Therefore, it would be expected that there would also be no difference in these rates in the counseling profession.

Pope and Vasquez (1991) indicate that based upon the findings of six national surveys there has been a consistent decrease in the rate of self-reported sexual intimacies over time; "from 12.0 - 12.1 percent for male therapists and 2.6 - 3.0 percent for female therapists...to 0.9 - 3.6 percent male therapists and 0.2 - 0.5 percent in the two most recent surveys" (p. 102-103) (cf. Borys & Pope, 1989; Gartrell, Herman, Olarte, Feldstein, & Localio, 1986; Holroyd & Brodsky, 1977; Pope et al, 1986; Pope, Levenson, & Schover, 1979; Pope et al., 1987). They suggest that the change in the self-reporting of these behaviors may be due to an actual decrease in the behaviors due to more awareness, the criminalization of the behaviors, or less genuine reporting (Pope & Vasquez, 1991). Considering that the number of complaints addressed to the Ethics Committees are continuing to escalate, it seems evident that mental health professionals are not abstaining from these behaviors. However, it is difficult to know just how much underreporting occurs in self-report studies (Eldelwich & Brodsky, 1991; Pope, 1988).

It is interesting to note that when graduate students were asked, in a survey, what ethical violations they should report and what they would report, there was a discrepancy (Bernard & Jara, 1986). Approximately, half of the students reported understanding the codes and knowing what they should report but, not always being willing to do so. A similar study (Wilkins, McGuire,
Abbott, & Blau, 1990) supports this finding. Therapists from Division 12 (Clinical) in APA consistently rated what they should do, higher than what they would do in facing ethical violations; the difference was statistically significant (Wilkins, et al., 1990).

**Sexual Dual Relationships**

Sexual dual relationships violate ethical principles, ethical codes, and all of the fundamental therapeutic conditions. The sexual intimacies between counselor and client constitute boundary violations that have been compared to those of incest and rape (Bates & Brodsky, 1989; Borys, 1988; Kardner, 1974; Pope, 1990a). Keith-Spiegel and Koocher (1985) maintain that "such behavior has been widely regarded as an abuse of trust and power and as desertion of the professional role and fiduciary duty" (p. 255). Even though these behaviors are so devastating to clients and counselors, they continue to remain the first or second most reported ethical violation.

This part will focus on the literature which provides a snapshot into the understanding of sexual dual relationships: sexual attraction, sexual involvement with current and former clients, and faculty and supervisor sexual involvement with students. There are three reasons for examining this research. First, this study investigates the ethicality ratings for two sexual involvements with clients (current and former). Second, given the paucity of research data on counselor/therapist characteristics and other variables in nonsexual dual relationships, it is important to examine the literature on sexual dual relationships for information that may extend to nonsexual relationships or that
may be utilized for comparison. Third, there is increasing empirical evidence of a relationship between nonsexual and sexual dual relationships. In general, findings suggest that professionals who violate or have liberal views regarding nonsexual boundaries are more likely to engage in sexual intimacies with clients (Borys, 1988; Holroyd & Brodsky, 1980; Kardner, Fuller, & Mensh, 1976).

Sexual Attraction

Two recent and innovative studies have initiated exploration on the topic of sexual attraction. Both are discussed below because these studies provide the only empirical evidence in this area. In the first study, Pope et al. (1986) indicated that most of the literature written before their research explored sexual attraction to clients as a form of transference-countertransference. They explained the components of the prominent view as follows:

First, the attraction was viewed as countertransference. Second, because countertransference represented the therapist’s own transference, the therapist was involved in a distortion (seeing the client in terms of a figure or conflict from the therapist’s past) of which he or she was unaware. Third, because the countertransference was an inappropriate or irrational response to the client’s transference, the therapist was, in effect, “mishandling” the transference phenomenon. As a result, a therapist’s attraction to a client became, almost by definition, a therapeutic error, something to hide and to be ashamed of. (Pope et al., 1986, p. 149)
This view has been perpetuated beginning with Freud and continuing through most of the psychoanalytic, psychodynamic, and object-relations literature. In fact, Pope et al. (1986) searched for literature outside of the psychodynamic theoretical orientation which dealt with sexual attraction but was unsuccessful, even after contacting several psychologists who were well known for their expertise on other theoretical orientation literature. This is a significant finding because not all theoretical orientations believe in a transference-countertransference concept.

In order to initiate empirical work in the area of sexual attraction Pope et al. (1986) mailed a questionnaire to 1,000 randomly selected psychologists. The return rate was 585 (58.5%). Their findings indicated that “87% (95% of men, 76% of women) have been sexually attracted to their clients, at least on occasion, and that, although only a minority (9.4% of men and 2.5% of women) have acted out such feelings, many (63%) feel guilty, anxious, or confused about the attraction” (Pope et al., 1986, p. 147). A majority (82%) had not considered participating in sexual intimacies with clients even though they may have felt attracted. In addition, over half of the therapists (69%) indicated that they felt the attraction had been beneficial with some clients. However, when taking into consideration whether the therapist thought the client knew of the attraction, the therapist felt more harm was done if the client was perceived to be aware. Of the therapists who did report sexual involvement with their clients, “86% did so once or twice, 10% did so between 3 and 10 times, and only one psychologist (female) reported a frequency of over 10 times” (Pope et al., 1986, p. 155).
There were four major reasons therapists reported for not participating in sexual intimacies with clients, because they were: unethical, countertherapeutic/exploitative, unprofessional practice, and against his/her personal views (Pope et al., 1986). Graduate training programs seem to be mostly silent or cursory in providing guidance on dealing with sexual attraction to clients; 79% indicated they had little or no training in this area.

The second study presents empirical data on therapists' sexual feelings and feelings of anger, hate, and fear. For the purposes of this discussion, only the data regarding sexual feelings are reviewed (cf. Pope & Tabachnick, 1993). The findings indicate that both female and male therapists (57%) have felt sexually aroused when with a client. Also, both male and female clients have been perceived by about one third of the therapists to be sexually aroused during therapy. In addition, a majority of the therapists (87%) in this study reported that they were sexually attracted to clients at least some of the time. This finding is consistent with the previously described study (Pope et al., 1986).

It is evident from both of these investigations into sexual attraction that a majority of therapists have found themselves feeling sexually attracted to clients. However, only a small portion of these therapists, according to self-reports, have acted out this attraction. Pope et al. (1986) found that consultation or supervision was sought out by 57% of the psychologists experiencing attraction to a client. How counselors/therapists cope with attractions to clients during the counseling/therapy session is still unanswered in the literature.
Sexual Involvement with Current and Former Clients

Professionals first began researching sexual dual relationships in the early 1970's. The first studies were intended to be exploratory and to provide initial guidance into the prevalence of such behaviors. Kardener, Fuller, and Mensh (1973) published one of the first empirical studies regarding attitudes and practices of erotic and nonerotic contact with patients. This research compared 460 male physicians practicing in different specialty groups: psychiatry, obstetrics-gynecology, surgery, internal medicine, and general practice. Kardener et al. (1973) found that 5 to 13% of the physicians reported they had engaged in erotic behaviors with clients. In particular, 5 to 7.2% indicated that this included sexual intercourse.

In a subsequent attempt to distinguish physicians participating in nonerotic vs. erotic contacts, Kardener et al. (1976) found that the demographic variables did not distinguish between these behaviors. Instead, it was the attitudes and practices of nonerotic behaviors that were the most statistically significant predictors of erotic contact. They indicated that the more liberal the attitudes and practices were regarding nonerotic behaviors, the more likely the physicians were to participate in sexual contact with the patient (Kardener et al., 1976). This has been a consistent finding in the literature from the Holroyd and Brodsky study in 1977 to the Thoreson et al. study in 1993.

Holroyd and Brodsky (1977) initiated the first national study of psychologists regarding the attitudes and practices of physical contact with clients. With a 70% return rate, they found that 5.5% of male and .6% of female psychologists reported engaging in sexual intercourse with clients. It was also
reported that "an additional 2.6% of the males and .3% of the females reported having had sexual intercourse with patients within three months after the termination of therapy" (Holroyd & Brodsky, 1977, p. 847). Three important findings were reported in this study. First, 80% of the psychologists who had engaged in sexual intercourse with their clients had repeated this behavior with more than one patient; the range was 1 to 200 and the median was six (Holroyd & Brodsky, 1977). Second, most of the perpetrators were male. Third, most of the clients involved were female. These themes have been reported repeatedly in the literature (Borys & Pope, 1989; Bounoutsos, Holroyd, Lerman, Forer, Greenberg, 1983; Gatrell et al., 1986; Glasser & Thorpe, 1986; Pope et al., 1986; Pope et al., 1979; Pope et al., 1987). It is interesting to note that in the Gatrell et al. study, most of the psychiatrists who had engaged in sexual contact admitted that it was for their "own sexual or emotional gratification" (p. 1129).

Information about therapist-client sexual intimacies has also been gathered by other means. Butler and Zelen (1977) interviewed 20 therapists who admitted to sexual contact with a client. It was reported that none of the therapists had a client make a formal complaint against them for these contacts. The therapists revealed "personal needs and motivations overwhelmingly contributed to the sexual contact" (p. 142). These needs included such things as "unsatisfying marriages, recent separations and/or divorces" (Butler & Zelen, 1977, p. 142). When asked what they thought about the nature of the relationship, 15% felt domineering and controlling towards the client and 60% reported being a "father-figure" (Butler & Zelen, 1977). After sexual contact was
initiated into the therapy process, 25 percent terminated therapy immediately, 30 percent continued therapy, and sexual behavior simultaneously throughout the therapy and 45 percent ceased the sexual activity and continued therapy with the client. A disturbing finding in this research was that only 40 percent of the therapists who engaged in sexual intimacies sought consultation (Butler & Zelen, 1977).

Bouhoutsos et al. (1983) and Pope and Vetter (1991) attempted another method of attaining information, they sent a questionnaire to therapists searching for therapists who had provided therapy to clients reporting sexual intimacy with their former therapists. Bouhoutsos et al. (1983) found that most of the previous therapists were male (96%) and most of the clients were female (92%). The mean age difference between therapist and patient was 12 years (therapist older). Therapists rarely were the ones to end the therapy after sexual intimacy and "in 78% of the cases, payments continued after sexual intimacies began" (p. 189). Overall, about 90 percent of the clients reported difficulties after the intimacy ended. In addition, the therapists who responded to the questionnaire and also reported sexual contact with their clients were more likely to report that the sexual intimacies in the previous therapy had no or minimal effect on the client (Bouhoutsos et al., 1983).

In the Pope and Vetter (1991) research, 87 percent of the clients who were sexually involved with a previous therapists were female. Approximately 12 percent of the clients had filed complaints against their former therapist. Interestingly, "female patients seen by subsequent psychologists were more likely to have been harmed by sexual intimacies that were initiated prior to
termination, whereas the male patients were not more likely to have been harmed by intimacies that were initiated only after termination” (Pope & Vetter, 1991, p. 433).

The researchers in this last study, have collected data on several different types of ethical behaviors (not just dual relationships). Pope et al. (1987), in a national study of psychologists, listed 83 behaviors and asked the therapists to indicated how often they engaged in the behaviors and how ethical they believed the behaviors to be. On items related to sexual intimacy, there was statistically significant differences regarding gender in three responses: females reported engaging in hugging clients more than males; males were more likely to tell clients they were sexually attracted to them, and; males were more likely to engage in sexual fantasies about clients (Pope et al., 1987). Over 90% of the therapists reported being sexually attracted to a client. In addition, "about half of the respondents believed that becoming sexually involved with a former client was unethical" (Pope et al., 1987, p. 1000). However, only 6.4% of the therapists believed it was unethical to become friends with a client after termination (Pope et al., 1987).

Controversy surrounds the issue of whether a therapist and client should engage in sexual intimacies after the termination of therapy. In a national survey of psychologists, Akamatsu (1988) found that 8.5% of the respondents reported that they believed sexual intimacies with former clients were somewhat or highly ethical, however, almost 30% were unsure if it was ethical or not. It is important to note that in this research 3.1% of the therapists reported sexual intimacies with current clients, while 11% reported sexual intimacies with clients
after termination. The increase of sexual intimacy behaviors with clients after the termination of therapy has been confirmed in other research (Holroyd & Brodsky, 1977; Gartrell et al., 1986; Thoreson et al., 1993).

Despite the empirical evidence that the majority of clients are harmed by sexual intimacies between therapists and clients, controversy still remains. Some professionals believe that sexual intimacy between therapist and client after termination should always be unethical (Brown, 1988; Hersen, 1992; Sonnenberg, 1992). Yet other professionals suggest that a one year waiting period after termination before commencing sexual intimacies with clients would probably be long enough and that these sexual contacts should not be deemed as totally unethical (Appelbaum & Jorgenson, 1991). Schoener (1992) proposed that if a client has been in long-term, intense therapy or has been sexually abused, sexual intimacies should always be prohibited, however, if this does not apply, there should be a two-year waiting period after termination.

Even though professionals themselves are divided about when or even if sexual intimacies are ethical after termination, ethics committees and boards manifest more certainty. Two studies have been published in which (Sell, Gottlieb, & Schoenfeld, 1986; Gottlieb, Sell, & Schoenfeld, 1988) state ethics committees and boards were surveyed to inquire about the types of complaints filed by clients. Both of these studies found that in a majority of cases, state ethics committees and boards did not accept the therapists' defense that because the sexual intimacies began after therapy terminated, it was ethical. In other words, the amount of time elapsed after termination of therapy was not a factor in adjudication (Gottlieb et al., 1988).
Faculty and Supervisor Sexual Involvement with Students

Except for addressing the issue of personal growth experiences within courses or supervision, the ACA Ethical Standards (AACD, 1988) are silent about the ethical responsibilities of faculty and supervisors to students. The relationships between faculty and supervisors with students present many opportunities for dual relationships. The obvious is sexual involvement, however, there are also numerous nonsexual dual relationships such as: a professor accepting an individual he/she is counseling into one of his/her courses; a supervisor providing counseling to a student as part of supervision, or; an advisor mentoring a student by providing an opportunity to be involved in research and to publish an article together. There is no agreement as to whether sexual intimacies during and after student-faculty relationships are ethical. However, a majority of professionals surveyed believed that it was unethical for faculty or supervisors to have sexual contact with students (Tabachnick et al., 1991).

Corey, Corey and Callanan (1993) state that supervisors "have a position of influence with their supervisees, in that they operate in multiple roles as a teacher, evaluator, counselor, model, mentor, and advisor" (p. 195). A majority of professionals, in order to become proficient in their counseling skills, participate in supervision with another, more established, professional. Supervision is at times similar or parallels the therapy process with the supervisee and client (Hart, 1982). Bernard (1987) indicates that "some models of supervision expect the supervisor to be in the therapist role" (p. 53). She also suggests that if collegial relationships make it difficult to maintain objectivity
on the part of the supervisor, consultation should be sought or the supervision relationship terminated.

Pope and Vasquez (1991) believe that supervision should focus on the supervisees' professional development; if personal concerns arise, the supervisee should be referred to another therapist for exploration of those issues. Typically, faculty provide supervision to graduate students during practica or internships. Both roles consist of inegalitarian relationships in which is implied an imbalance of power. Kitchener (1992) states that "clearly, power has been identified as a culprit in cases of sexual exploitation of students" (p.191).

The prevalence of faculty/supervisor-student sexual relationships appears to be extensive. The results of four national surveys are presented below.

Pope et al. (1979) surveyed psychologists who were members of the APA Division 29 (Psychotherapy). This national survey found that 1 out of every 4 (25%) recent (within the last 6 years) female graduates reported sexual contact with an educator; the figure was 16.5% for females overall. However, only three percent of the male students reported sexual contact with educators. Pope et al., (1979) stated:

For females, 75% of those who had had sex as a student with a psychology educator had done so with teachers, and 47% had done so with clinical supervisors. For males, the figures were reversed. Most males reporting sex as a student had done so with their clinical supervisors (86%) rather than with psychology teachers (29%). (p. 685)
The second study investigated female members only in the APA Division 12 (Clinical) and found that “sexual contact is quite prevalent overall (17%) and among recent doctoral recipients (22%) and among students divorcing or separating during graduate training (34%)” (Glasser & Thorpe, 1986, p.43). It was also found that 31% of the psychologists reported that sexual advances were made to them as students by educators. When the sexual contact occurred 28% of the respondents reported that they felt coerced, however, at the time of the survey, 51% viewed it as coercion (Glasser & Thorpe, 1986). These figures are similar to those reported by Pope et al. (1979).

The third study investigated 482 psychologists who were members of the APA Division 2 (Teaching of Psychology) (Tabachnick et al., 1991). Each respondent was asked to rate 63 behaviors related to teaching on the extent to which they engaged in the behavior and how ethical they believed it to be. There were seven behaviors that were reported more frequently for teachers than clinical psychologists: asking small favors of a student; working while too distressed to be effective; becoming sexually involved with a student; lending money to a student; attending a student’s party; selling goods to students, and; becoming sexually involved with a student after a class has ended (Tabachnick et al, 1991).

In the fourth and last study the attitudes and practices of 336 male counselors, selected from the ACA, were solicited regarding sexual contact with clients, students, and students in supervision (Thoreson et al., 1993). The reported sexual contact between counselor and client during therapy was 1.7 percent, however, when respondents were asked to report contact with clients
after termination the figure increased an additional 7 percent (total = 8.7%). When respondents were asked to include current clients, students, and students in supervision with whom they have had sexual contact, 17% reported this contact; 21.6% reported contact with this population after termination of the professional relationship (Thoreson et al., 1993). Five percent of the respondents reported that they had engaged in sexual contact with their counselor, educator, or supervisor when they were a student. Thoreson et al. (1993) report that these figures match those reported by Glasser and Thorpe (1986) which investigated female graduate students' sexual contact.

Sell et al. (1986) believe that "unethical sexual behavior continues to occur largely because of the failure of faculty to act as models of appropriate social and sexual behavior" (p. 508). As indicated by the literature in social psychology, modeling speaks louder than words. There are other professionals who blame poor training due to the lack of teaching about how to deal with sexual feelings (Bounoutsos, 1985; Pope, Sonne, & Holroyd, 1993).

**Nonsexual Dual Relationships**

Keith-Spiegel and Koocher (1985), Herlihy and Corey (1992), as well as other professionals, agree that nonsexual dual relationships are difficult, if not impossible, to avoid. This is particularly true in settings of higher education, in rural communities, or within minority communities (Horst, 1989; Kitchener, 1988; Stockman, 1990). Kitchener (1988) indicates that there are problems with nonsexual dual relationships due to conflicts that arise from the incompatibility of expectations and obligations for each role, loss of objectivity, and the differential of power and prestige. She indicates that as the incompatibility of
these conflicts increase, the potential for harm to the client, supervisee, or student also increases. Therefore, it is necessary for professionals to monitor these relationships carefully, if they can not be avoided.

Borys (1992) relates five causes for most nonsexual dual relationships: (a) the emotional vulnerability of the client; (b) unmet emotional needs or unresolved conflicts on the part of the therapist; (c) a strong countertransference reaction on the part of the therapist resulting from unmet emotional needs; (d) rationalization or denial of the unethical and countertherapeutic nature of acting out the countertransference; and (e) a clinical practice with little role distance between client and therapist, little surveillance, and/or few institutional barriers against dual relationships. (p. 448)

These factors often interact with each other.

Literature relating specifically to nonsexual dual relationship issues is scarce. Most dual relationship research either reports respondents' reactions to general ethical issues, of which some relate to nonsexual dual relationships, or it has been focused on the sexual relationship aspect. In this part, two recent national investigations which elicited responses to general ethical behaviors are discussed. Only results from the nonsexual dual relationship behaviors are reported. In addition, three national empirical studies specifically addressing nonsexual relationships are also be discussed.

Pope et al. (1987) surveyed 1,000 members from APA Division 29 (Psychotherapy) regarding how often they engaged in 83 behaviors and to what extent they thought the behavior was ethical. The return rate was 45.6%
(N = 456); 231 males and 225 females. All of the items reported below relate specifically to nonsexual dual relationship issues. Four items were endorsed as being mostly (90%) ethical: self-disclosing to clients; accepting a gift from a client worth less than five dollars, and; offering a handshake to a client. Three items were endorsed as mostly unethical by a majority of the respondents: borrowing money from a client; going into business with a client, and; giving a gift to a client of at least 50 dollars. Difficult judgements were items rated by at least 20% as "not sure." The items in this category were: accepting goods (rather than money) as payment; being sexually attracted to a client, and; inviting clients to an open house (Pope et al., 1987). It is interesting to note that only 6.4% believed that becoming friends with a former client was unethical, however, 42.1% indicated they had never engaged in this (Pope et al., 1987).

In a similarly patterned study, Gibson and Pope (1993) surveyed 1,024 certified counselors regarding how ethical they believed 88 behaviors to be and how confident they were in their assessment. The return rate was 59 percent (N = 579). Sixty-eight percent of this sample were members of the ACA. This research is important because it is the first empirical study to collect data regarding the ethicality of behaviors utilizing a counselor sample. Gibson and Pope (1993) indicate that "only two national studies of counselors' ethical discrimination have been published" previous to their research (p. 330; cf. Shertzer & Morris, 1972; Robinson & Gross, 1989).

Only one nonsexual relationship item was endorsed by 90 percent of the respondents as ethical: offering a handshake to a client. The nonsexual dual relationship items were the same as those in the Pope et al. (1987). Both of the
difficult judgement endorsements, in which respondents were the least confident about related to bartering. Gibson and Pope (1993) created a category for controversial items in which 40 percent of the respondents endorsed as ethical and 40 percent endorsed as unethical. Included in these items were five nonsexual dual relationship items: providing counseling to one of your employees; going into business with a client; becoming social friends with a former client; inviting clients to an open house, and; providing counseling to student/supervisee (Gibson & Pope, 1993).

In addition, older respondents endorsed the following counseling practices significantly more than younger respondents: providing counseling to a friend, providing counseling to a student, providing counseling to a supervisee, and providing counseling to an employee (Gibson & Pope, 1993). Gibson and Pope (1993) believe this may be due to the recent emphasis on nonsexual dual relationship behaviors in ethics courses, of which older respondents would not have benefited.

Two national studies have been conducted specifically for the purpose of investigating nonsexual dual relationship behaviors (the exception being two items regarding sexual dual relationships). Both of these studies have provided the foundation for the present study.

Borys (1988) initiated the first national study comparing three disciplines in attitudes and practices of nonsexual dual relationship behaviors. This study was published by Borys and Pope (1989). A random sample of 4,800 clinicians, stratified by gender, were selected from the APA, the American Psychiatric Association, and the NASW. Three conditions were set for selection
of the sample, they had to be licensed, currently practicing therapy, and working with an adult population. The response rate was 2,332 (49%); 42.4% were psychologists, 26.7% were psychiatrists, and 30.8% were social workers.

Two forms of the Therapeutic Practices Survey (TPS) were developed; one to survey how ethical the respondents believed a behavior to be ("Ethics" form) and one inquire how frequently they engaged in the behavior ("Practices" form). A factor analysis of the TPS resulted in three factors: Factor 1, Incidental Involvements such as occasions that occurred once or only on special occasions; Factor 2, Social/Financial Involvements such as becoming friends with a client or selling a product to a client, and; Factor 3, Dual Professional Roles such as providing therapy to a relative or allowing a client to enroll in one's class. Demographic information was also collected which included: "therapist gender, profession, age, experience, marital status, region of residence, client gender, practice setting, theoretical orientation, and practice locale" (Borys & Pope, 1989, p. 283).

The findings indicated that there were no significant differences among the three professions regarding sexual intimacies before and after termination of therapy or with any of the three factors on the TPS (Borys & Pope, 1989). However, other differences are described below:

In general, psychotherapists who were male, non-psychiatrists, non-psychodynamically-oriented, private practitioners, living and working in a small town, and/or from the Midwest or South tended to rate each type of dual role behavior as more ethical and
reported engaging in them with more clients than their counterparts. (Borys, 1988, p. xvi)

It is also important to note that the respondents who reported engaging in sexual intimacies with clients after termination also endorsed more nonsexual dual relationship behaviors as being ethical. Borys (1988) suggests that the violation of nonsexual behaviors may lead to the violation of sexual boundaries. Specific findings regarding ethically and demographic variables are discussed individually in the Demographic Variables section.

The second national study relating specifically to nonsexual dual relationship behaviors was conducted by Baer (1991). Baers' research (1991) was modeled after the Borys' study (1988) and utilized the same TPS forms with minor adaptations. Baers' (1991) design, however, allowed for more accurate measurement of gender of clients. In addition, therapist characteristics were added to her study which brought another dimension to this area of research.

Baer (1991) randomly selected 600 psychologists (300 male and 300 female) from APA with the same criteria that was used in the Borys' (1988) research. Each sex of therapist was paired with each sex of client (4 groups; 150 therapists in each group). The return rate was 230 (37%). The variables studied were: theoretical orientation, therapist's degree of differentiation and level of stress, therapist's sex and client's sex (Baer, 1991).

Differentiation and stress were based on family systems theory. Differentiation measured the separateness of the respondent from the family of origin. Stress was measured as general/personal life stress. In other words,
general questions about satisfaction of relationships, work, and finances were measured.

An interaction between differentiation and stress was found for two of the three subscales on the Ethicality Assessment Survey (EAS); incidental and dual relationship. Specifically, “low differentiated/high stressed therapists endorsed more involvements as ethical when compared to low differentiated/low stressed therapists” (Baer, 1991, p. 108-109). This result was expected and supported the family systems theory. However, therapists who were high differentiated/low stressed, endorsed more involvements than the high differentiated/high stressed therapists on both the dual relationship and incidental subscales (Baer, 1991). This finding contradicted the systems theory.

Baer (1991) suggested that another variable such as “ambiguity tolerance” may intervene with stress and differentiation during ethical decision making. It may also be that the type of stress measured (personal rather than occupational) or possibly anxiety rather than stress (Alber, 1991) may be a better indicator. Baers’ (1991) findings also supported prior research on gender bias in that male therapists reported more ethical involvements than female therapists, however, her results suggested that male clients endorsed more involvements for male than female clients. Previous research supports the finding that male therapists endorse more involvements than female therapists with male clients (Boghoutsos et al., 1983; Holroyd & Brodsky, 1977; Gabbard & Menninger, 1991) but typically, male therapists have endorsed more behaviors with female rather than male clients.
Therapeutic Stress

There have been volumes of works published which investigate the area of stress (Goldberger & Breznitz, 1982), strain (Leatz., & Stolar, 1993), work overload (Keenan & McBain, 1979), role conflict (Jackson & Schuler, 1985), role ambiguity (Kahn, Wolfe, Quinn, Snoek, & Rosenthal, 1964), and burnout (Edelwich & Brodsky, 1980; Maslach, 1982). The topic of occupational stress has, also, received much attention in the literature. Unfortunately, it is beyond the scope of the present study to begin to explore all of these areas, instead, this review focuses more specifically on stress which occurs in the therapeutic milieu. The study of therapeutic stress is important given that in the literature there are reports that the personal distresses of therapists contribute to their vulnerability in the violation of boundaries (sexual and nonsexual) and maintenance of care (Butler & Zelen, 1977; Bates & Brodsky, 1989; Guy, Poelstra, & Stark, 1989; Pope et al., 1987).

Therapeutic stress in the present study relates to the specific stresses associated with the work role of a counselor. Two different strategies have been applied in the investigation of stress in the counseling process: stress resulting from counseling difficult clients and stress from the professional role.

In exploring the effect that clients have on therapeutic stress, Deutsch (1984) found that therapists consistently rated suicidal statements as the most stressful client behavior and indicated that counseling suicidal clients accounted for approximately 11 percent of the therapists time during each week. Other stressful client behaviors reported by therapists were as follows: the expression of anger toward the therapist, clients with major depression, apathy, and clients
terminating prematurely. In a prior study on the stresses of psychotherapeutic work, Farber (1983), reported almost identical findings. Other investigations provide additional support. For example, Hellman and Morrison (1987) found that therapists who reported case loads with more disturbed clients also reported more stress, particularly, in maintaining the therapeutic relationship with these clients. They also found that private practice therapists reported less personal depletion but more stress related to client pathology. Additionally, Hellman, Morrison, and Abramowitz (1987a) reported three patient behaviors that were most stressful to therapists: "psychopathological symptoms, suicidal threats, and passive-aggressive behaviors" (p. 175).

Several investigations have also studied the other strategy, that is, to focus on the contribution of the therapist or the professional role. Psychologists’ professional impairment was investigated in a study of 52 psychologists who had worked in the field for an average of 14 years (Overholser & Lehnert, 1993). The findings indicated that the most common problems reported by psychologists were "job stress and burn-out, family and marital problems, depression, stress and anxiety, mishandled countertransference, and dual relationships (Overholser & Lehnert, 1993, p. 23). Approximately 70 percent of the respondents reported burnout/overwork and 50 percent experienced a stress or anxiety disorder. Similar findings were also reported in another survey using the same instruments with a different population of psychologists (Brodie & Robinson, 1991).

In an investigation related to the endorsement of ethical behaviors, Baer (1991) included stress as a variable in her research with psychologists to
investigate the relationship between stress and differentiation. Stress was measured in a general way pertaining to life events and feelings. She expected to find that high differentiated/low stress respondents would endorse less issues as ethical. However, she found that high differentiated/low stress respondents endorsed the most involvements on the dual relationships scale. Based on this finding, she suggested that there is a variable(s) that intervenes with stress and proposed that ambiguity for tolerance may be that variable.

Farber and Heifetz (1982) investigated therapeutic stress as a variable with psychologists in general practice. The measure utilized was developed to specifically measure stress resulting from being a therapist. They found that work overload was the most stressful factor for psychotherapists. Hellman, Morrison, and Abramowitz (1986) also investigated therapeutic stress with psychologists and found that therapists with heavy case loads reported more stress from maintaining the therapeutic relationship, scheduling, and professional doubt. In a similar study, Hellman, Morrison, & Abromowitz, (1987a) found that older and more experienced therapists reported less stress in work-related factors, however, caseload was a moderating variable. In other words, therapists who reported too much or too little time counseling clients were more vulnerable to stress regardless of age or experience (Hellman, Morrison, & Abromowitz, 1987a).

Finally, Hellman, Morrison, & Abromowitz (1987b) investigated work stress in relation to flexibility/rigidity. Since flexibility/rigidity has also been associated with intolerance of ambiguity, a measure for intolerance of ambiguity was utilized to measure flexibility/rigidity. It was thought that since a therapist’s
work was mostly spontaneous when working with clients, that being more rigid or intolerant would produce more stress. Hellman, Morrison, & Abromowitz (1987b) also measured therapist boundary preference. They believed that stress would affect boundary management. The findings indicated that rigid therapists did report more stress on the client variables of negative affect and suicidal threats but there was little correlation with professional work factors. Also, as hypothesized, therapists with higher boundary levels reported less stress (Hellman, Morrison, & Abromowitz, 1987b).

Since dual relationship ethical behaviors are associated with professional duties it is thought that therapeutic stress would be more likely to contribute to the endorsement of behaviors rather than a measure of general life stressors. This is also important due to therapists reporting that work related stresses such as maintaining the therapeutic relationship, professional doubt, and personal depletion contribute to their stress level. Therefore, therapeutic stress was included as a variable in the present study.

**Personal Boundary Preference**

As previously indicated, individuation (differentiation) is the ability to maintain separateness from others present in the social environment. Miller (1970) states that the "greater the sense of separateness and distinctiveness from others in his social network and from his sense of self in the past, the more articulated or impermeable are his boundaries said to be" (p. 1). Boundaries tend to be vague and nondistinct during infancy and become less penetrable and more defined as the individual develops. This is not to imply
that boundaries become impervious, however, they tend to be stable enough to provide a sense of self yet flexible enough to adapt. "Ego strength results from the ego's ability to maintain relatively stable ego boundaries under moderate stress. This provides for a continuing sense of personal identity and avoids states of irreality" (King & Neal, 1968, p. 81).

Boundaries are an essential part of the therapeutic process and therapists are the gatekeepers of boundary exchanges. Greene and Geller (1980) indicate that "the capacity for empathy involves a loosening of personal boundaries and a partial merging with the patient...however, [role requirement] imposes limitations on the exchanges from therapist to patient in terms of self disclosures and gratification of personal needs" (p. 32). In essence, counselors make decisions during the therapy process regarding what is personal about him/herself or nontherapeutic to share and what may be "role relevant" (Greene & Geller, 1980 p. 32). Regulation of self boundaries may become clouded or more difficult during different phases of the therapy process. For example, Greene & Geller (1980) found that during termination of clients from therapy, students tended to "abandon the therapeutic role for personal needs for isolation and intimacy" (p. 33). In other words, some students backed away from the client to strengthen boundaries, during this emotionally intense time, while other students tended to move closer to the clients blurring the professional boundary (Greene & Geller, 1980).

The literature suggests that another difficult time for self boundary regulation is during transference and countertransference (Gabbard, 1991; Pope et al., 1993; Simon, 1989; Strasburger, Jorgenson, & Sutherland, 1992;
Teitelbaum, 1991). During transference, "clients transfer feelings, attachments, or styles of relationship associated with figures from their past (such as parents) onto the therapist" (Pope & Vasquez, 1991, p. 39). These feelings are intrinsic in the client and are exposed by the therapist through the utilization of the fundamental therapeutic conditions. Strasburger et al. (1992) indicate that "transference also plays a role in the sexualization of therapy. Infantile yearnings are revived and enacted in the context of therapy, often taking the form of sexualized dependent striving" (p. 545). They go on to say that if the therapist confuses these wishes to think it applies to him/her personally, boundary violations could occur. Many professionals believe that it is the mishandling of countertransference that contributes to dual relationship behaviors among therapists (Pope et al., 1986). Countertransference has two components: "(a) The therapist's reaction is irrational or distorting -- that is, a transference; and (b) the therapist is reacting to the client's transference" (Pope et al., 1986, p. 149). It is interesting to note that boundary violations are unilaterally explained from psychodynamic orientation even when the orientation does not include these terms in their theory (Pope et al., 1986).

It has been suggested that sexual boundary violations occur after a gradual loosening of the nonsexual boundaries in therapy (Strasburger et al, 1992; Pope et al, 1993). The therapists may begin sharing more about themselves during the therapy sessions, asking the client for favors outside of session time, walking him/her to the car, touching him/her more often, and so forth. Gradually the boundaries are blurred and confusion may begin about
what are the needs of the therapist and what are needs of the client (Gabbard, 1991).

The dynamics of the therapeutic relationship could be viewed as somewhat parental in light of the transference experienced by the client. It is important to note that in the findings of Butler and Zelen (1977), 70 percent of the therapists interviewed reported feeling dominating, controlling and/or like a father-figure to the women with whom they were sexually intimate. Because of the power differential, therapeutic dynamics (i.e., transference-countertransference and the reliance on the curative factors such as trust, genuineness, caring), and dependence of the client on the therapist, the client is often in a vulnerable position. Borys (1988) summarized the relationship between sexual and nonsexual dual relationship behaviors by reporting that when a breakdown occurs in the nonsexual boundaries there becomes an increase in the risk of the therapist and client becoming sexually intimate. Several researchers indicate that these relationships are not unlike those of familial incestual situations or rape (Borys, 1988; Butler & Zelen, 1977; Kardener, 1974; Pope, 1990a).

In previous studies, individuation has been investigated in relation to the family of origin, in accord with family systems theory. Baer (1991) and Alber (1991) both investigated this variable in relation to stress. Baer (1991) found partial support of the family systems theory (see section Therapeutic Stress for discussion) and Alber (1991) found total support; lower differentiation was significantly associated with higher anxiety and stress.
The instrument utilized in the present study (Personal Boundary Scale (PBS); Miller, 1970) does not measure separateness from family. The PBS measures degree of distance from others and the environment. It was thought that the less able a counselor is to keep boundaries around certain interactions and behaviors, the more the counselor will endorse behaviors. The more boundaries, and better formed boundaries, the less ethical behaviors endorsed. Thus, boundary-fusion tendencies should contribute to ethical endorsements as measured by the PBQ (Miller, 1970).

**Tolerance For Ambiguity**

Tolerance for ambiguity is "the degree to which a person can cope effectively with unstructured or open-ended situations" (Foxman, 1980, p. 455). Frenkel-Brunswik (1949) focused on this construct regarding it as "one of the basic variables in both the emotional and the cognitive orientation of a person toward life" (113). Budner (1962) defined intolerance of ambiguity as "the tendency to perceive (i.e. interpret) ambiguous situations as sources of threat" (p. 29). In other words, depending on how ambiguity is viewed, as positive or negative, resolves how an individual will react (i.e., seek it out or to be threatened). Budner (1962) believed ambiguity tolerance to be as a way of evaluating a situation but was not to be considered a coping mechanism. This view would suggest it is a variable that would act as a moderator for other variables. Budner (1962), Rydell (1966), and MacDonald (1970) all became interested in Frenkel-Brunswik’s concept and developed instruments by which tolerance or intolerance for ambiguity could be measured. Ambiguity tolerance
has been studied in relation to medical student selection and training (DeForge & Sobal, 1989; Geller, Faden, & Levine, 1990), playfulness and creativity (Tegano, 1990), ethnocentrism, and occupational role stress-strain (Frone, 1990).

Frone (1990) ran a meta-analysis of 13 independent studies (1971-1985) to observe if intolerance of ambiguity would act as a stress moderator. He found "strong support to the moderating effect" (p. 315). In other words, intolerance for ambiguity is a moderator variable for role stress and strain, however, Frone (1990) cautions that other variables may also moderate role stress such as work overload or intolerance of conflict (Frone, 1990).

There appears to be a very limited use of the construct tolerance for ambiguity in the area of counseling. More specifically, no empirical research was located which would provide insight on the contribution of tolerance for ambiguity to the endorsements of ethical behaviors.

**Gender**

One of the most consistent findings in sexual and nonsexual dual relationship research is that of gender bias. Male therapists, regardless of discipline, endorse more involvements as being ethical and report engaging in more of these behaviors than do female therapists. In addition, clients, students, and/or supervisees with which these behaviors are acted out tend to be female (Borys & Pope, 1989; Holroyd & Brodsky, 1980; Pope, 1990b; Pope et al., 1979; Pope et al., 1986; Pope & Vetter, 1991; Stewart, 1991). The AACD (ACA) Ethics Committee Report for 1989-1990 indicated that 70 percent of the
total cases were filed against men and 70 percent of the complainants were women (AACD, 1991). In addition to reporting the findings above, Pope et al. (1986), also found that male therapists reported "physical attractiveness" and women reported "successful" as characteristics of clients that elicited sexual feelings.

The differential treatment of women in therapy, supervision and higher education is important to understand, given the indication from the literature that it is the differential touching of an individual that is more likely to lead to intercourse (Holroyd & Brodsky, 1977). In other words, when a professional constricts touching to one sex more than the other, sexual intimacies are more likely to occur. A call has recently been put forward to challenge psychologists to respond beyond individual psychology in dealing with the problem of male violence against women. It has been suggested that a move to change social and cultural institutions is necessary to change this alarming rate of abuse (Biden, 1993; Browne, 1993; Fitzgerald, 1993; Goodman, Koss, Fitzgerald, Russo, & Keita, 1993; Koss, 1993).

**Demographic Variables**

Several demographic characteristics have been investigated in relationship to sexual and nonsexual dual role behaviors. Some research has provided information regarding counselor characteristics which might make a counselor more vulnerable and likely to engage in dual relationships. Others have not been manipulated and have mainly been used for descriptive purposes. The following characteristics have been included in the present
study: ethnic origin, age, marital status, sexual orientation, degree, certification and/of licensure, work setting, counseling/therapy provided in the last five years, experience, theoretical orientation, and social isolation.

**Ethnic Origin**

Ethnic origin information was collected, in the present study, for comparison of respondents in the early, late and nonrespondent groups and to determine the representativeness of the sample with the population. In previous studies, this has not been utilized as an independent variable, therefore, there is no information on whether there are response differences among different ethnic origins. For example, Borys (1988) did not collect this data and Baer (1991) reported her sample as being 95.5 Caucasian which was consistent with the population of psychologists.

**Age**

There are two important findings with regards to age and therapists’ sexual intimacies with clients. First, therapists were found to be significantly older than the client(s) with whom they became sexually involved (Bouhoutsos et al., 1983; Gartrell et al., 1986). The average difference in age was 16 years (Bates & Brodsky, 1989). Second, in a national study (Bajt & Pope, 1989) therapists were found to have been sexually intimate with clients who were minors. Client ages ranged from 7 to 16 and 3 to 17 for boys and girls, respectively.
Marital Status

Married and unmarried counselors "generally differ little in their ethics" (Edelwich & Brodsky, 1991, p. 85). However, Edelwich and Brodsky (1991) also report that if professionals experience difficulty in their intimate relationships, they may be more susceptible to violating sexual boundaries with clients. Bates and Brodsky (1989) describe a psychologist at risk as being "involved in unsatisfactory love relationships in his own life, and perhaps going through a divorce" (p. 135). This composite description of therapists at risk for ethical violations is repeated several times in the literature. Thoreson et al. (1993) found marital status significantly correlated with sexual contact with clients, students, and supervisees; counselors who were divorced or single reported more incidences.

However, marital status seems to be a variable collected mostly for the purpose of sample and population comparisons. In a recent study, Borys (1988) utilized marital status as an independent variable but found no significant differences between marital status and reported ethical attitudes or practices of ethical behaviors.

Sexual Orientation

There has only been one study where sexual orientation was included as a variable in research on sexual contacts of male counselors (Thoreson et al., 1993). They found that male heterosexuals reported "more conservative attitudes toward sexual contact occurring outside of the professional relationship" (p.431). Homosexuality was significantly correlated with sexual
contact with a client, student under supervision, or student (Thoreson et al., 1993). Additionally, Gartrell et al. (1986) investigated psychiatrist and patient sexual contact in a national study. They found that 7.6% of contact occurred between male psychiatrists and male patients and 1.4% between female psychiatrists and female patients.

In an investigation of nonsexual dual relationships, Baer (1991) found that male therapists endorsed more ethical items for male clients than female therapists did for male clients. This has been supported in other research (Bouhoutsos et al., 1983; Holroyd & Brodsky, 1977; Gabbard & Menninger, 1991). Baer (1991) suggested that therapists “may think that involvements with same-sex clients are less open for misinterpretation by the client” (p. 115). However, in one investigation it was reported that 67% of male therapists and 58% of female therapists thought that nonerotic contact might be misunderstood by opposite-sex clients and 63% and 52%, respectively, for same-sex clients (Holroyd & Brodsky, 1977). All combinations of therapist-client gender pairings have been brought to litigation (Gutheil & Gabbard, 1992). It is evident that sexual orientation in relation to dual relationships needs further empirical investigation.

**Highest Degree**

Thoreson et al. (1993) studied the attitudes and practices of male counselors regarding sexual contact with clients before and during counseling. Their findings confirmed prevalence of sexual contact “for the predominantly master’s level counselors that is similar to that reported for doctoral-level clinical
and counseling psychologists" (p. 432). Most other researchers have studied psychologists or psychiatrists who have doctorates. However, as reported earlier, Borys' (1988) sample contained social workers (who typically have a masters degree), psychologists and psychiatrists (who typically have a doctorate degree) and she found no significant differences between the groups on attitudes or practices of sexual intimacies.

Pope (1990b) states that "no research data reported in peer-reviewed journals supporting the premise that therapists who become sexually involved with their patients tend to have less formal education or to have received less professional recognition" (p. 484). In fact, he indicates that the literature provides data supporting a higher rate of sexual involvement from professionals who are successful in their field (Pope, 1990b).

Certification and/or Licensure

Within the field of counseling, certification, licensure, and registration are a recent phenomenon; in 1987, only seven states were actively licensing counselors (Herlihy, Healy, Cook, & Hudson, 1987). This has expanded to 34 states in 1992 (Neukrug et al., 1992). Licensure, certification, and registration promotes professional identity and provides codes to which counselors adhere (Neukrug et al., 1992).

The ACA is an umbrella organization which includes members licensed, certified, and registered by several different agencies. It was developed to represent the interests of professional counselors, however, psychologists, and social workers are also included in the membership. Since this is an initial
study, this variable will be utilized only in reporting frequency of members certified/licensed or not certified/licensed.

Only one national study has compared licensed members in different professions (Borys & Pope, 1989). No significant differences were reported between psychiatrists, psychologists, and social workers in the rates in which they engaged in sexual intimacies with clients (Borys & Pope, 1989).

Work Setting

Empirical research in sexual dual relationships has indicated that therapists in private practice engage in significantly more sexual contact with clients, students, and/or supervisees than therapists in other work settings (Bouhoutsos et al., 1983; Kardener, 1974; Thoreson et al., 1993). Borys (1988) was the first to study this aspect in relation to nonsexual dual relationship behaviors. She hypothesized that private practitioners more than those in other work settings would endorse more involvements as ethical. The hypothesis was true for only some ethicality attitudes and practices. Specifically, only Incidental Involvements were endorsed as more ethical and only Incidental and Financial Involvements were reported as practiced with more frequency.

Counseling/Therapy Provided within Last Five Years

There are counselors who work in administrative positions or in other areas outside of counseling. Some may also be student or retired ACA members. This item was included on the DIQ to screen out subjects who were
not currently performing counseling services. This variable was also included in two previous studies for the same purpose (Baer, 1991; Borys, 1988).

Experience

Previous studies have yielded mixed results on the variable of professional experience (Borys, 1988; Holroyd & Brodsky, 1980; Kardener et al., 1976; May & Sowa, 1992). Kardener et al. (1976) found no significant differences in the amount of professional experience between respondents who engaged in sexual contact and those who did not on this variable. However, Holroyd and Brodsky (1980) reported that older therapists who had been in practice longer tended to engage in erotic touch which did not lead to sexual intercourse. They also tended not to engage in touching one sex of client more than the other and reported touching rates similar to other therapists.

Borys (1988) found mixed results in her study. On the scales of social/financial younger clinicians endorsed more items. However, on the dual professional relationship scale, more experienced clinicians endorsed higher ethical ratings. In addition, May and Sowa (1992) did not find any statistical significance between the years of experience and the amount of stress perceived in making ethical decisions.

Theoretical Orientation

Theoretical orientation has been investigated as a counselor characteristic related to ethical research. Counseling is typically based upon theory. Issues in counseling are often interpreted in light of the professional's
theoretical orientation such as humanistic, psychodynamic, gestalt, or behavioral. Theoretical orientations tend to differ in the amount of distance the professional is suggested to maintain from the client; environmentally, socially, and personally.

The literature suggests that mental health professionals whose theoretical orientation is psychodynamic endorse less behaviors as being ethical and report less frequency of these behaviors. For example, Holroyd and Brodsky (1977) found that approximately 25% of the humanistic therapists frequently or always engaged in nonerotic contact behaviors. This was significantly more than other orientations: psychodynamic, behavior modification, rational-cognitive, 5% each, and eclectic, 10%. There was also a significant difference between theoretical orientations and perceived benefits from nonerotic contact: 30% of humanistic therapists believed it might be beneficial to clients frequently or always and 6% of the psychodynamically oriented therapists believed this (Holroyd & Brodsky, 1977). However, for the total number of sexual contacts, there were no reported significant differences between theoretical orientations (Holroyd & Brodsky, 1977). Additionally, Borys (1988) and Baer (1991) found that psychodynamically oriented therapists rated dual relationships as more unethical than the other orientations.

**Social Isolation**

Few previous studies which have questioned the role of social isolation in regards to sexual and nonsexual dual relationships. Glasser and Thorpe (1986) suggested that social isolation may explain why divorced and separated
students engaged in more sexual intimacies with faculty and supervisors. Obviously, this would have put the students in a more vulnerable state. Therapists also have reported disruptions or dissatisfaction in their relationships as reasons for sexual intimacies with clients (Bates & Brodsky, 1989; Edelwich & Brodsky, 1991; Kardener, 1974; Thoreson et al., 1993).

Borys (1988) investigated social isolation in relation to solo or group private practice. She found that “solo private practitioners reported significantly higher levels of social isolation in their practice setting than clinicians in private practice and all other settings” (Borys, 1988, p. 172). In addition, therapists in private practice endorsed Incidental Involvements as more ethical and reported participating in Incidental and Financial Involvements more frequently than therapists in other settings.

**Summary**

The literature is clear. Despite ethical codes being explicit about sexual intimacies as unethical between client and therapist, it is still occurring. Silence in the codes about such relations after termination of counseling and with students or supervisees allows for personal interpretation which may or may not be ethical. Many training programs still do not have specific courses in ethics and those that do seldom go beyond the codes. Training in ethics often lacks discussion of sexual feelings even though the literature shows these feelings frequently occur during therapy (Pope, Sonne, & Holroyd, 1993). In addition, when sexual contact between faculty and supervisors with students and supervisees continues to be ignored within training programs, modelling occurs
that may undermine the classroom training. In effect, the behaviors model that
sexual contact is acceptable, at least for certain individuals. Ethical principles
and theories, which provide the foundation for codes, must be examined along
with ethical decision making models to provide a broader base for behaviors,
especially those not covered by specific codes.

In order for therapy to be effective, certain therapeutic conditions need to
be present such as genuineness, empathy, and unconditional positive regard
(Rogers, 1957). In addition, an imbalance of power develops from the
dynamics inherent in the counseling relationship. Boundaries are set up and
maintained within the therapeutic relationship for the security and protection of
the client, as well as to promote the development of therapeutic conditions.
When these boundaries are eroded, so too, are the therapeutic conditions.
Several variables have been studied in relation to sexual and nonsexual dual
relationships such as general life stress, differentiation of therapist from the
family-of-origin, gender, marital status, work setting, experience, social isolation
and theoretical orientation. The literature shows that attitudes about sexual
conduct and previous sexual intimacies with clients seem to be the most
important factors in predicting actual sexual conduct.

Nonsexual dual relationship behaviors have only recently begun to be
empirically investigated. A review of the literature yielded only four studies
which have focused on the nonsexual aspect of dual relationships (Baer, 1991;
Borys, 1988; Darling, 1991; Sharkin & Birkey, 1992). Throughout this review,
gender emerges as a central issue: male therapists tend to endorse more items
as being ethical for nonsexual and sexual dual relationships than do women
therapists. They also report acting these behaviors out with more female clients than male clients.

Recently, explorations of therapist characteristics have begun with regards to how much they contribute to ethical attitudes, which have been shown to be good predictors of behaviors. Borys (1988) was the first to focus an investigation on nonsexual dual relationship behaviors. She studied the relationship of therapist practices and attitudes in nonsexual behaviors. Baer (1991) added therapist characteristics such as differentiation from family, general life stress, and a more refined measure of gender of client in relation to nonsexual behaviors.

The present study was designed to explore the attitudes of nonsexual dual relationship behaviors in relation to: personal boundary tendencies which is the differentiation of self from social environment instead of family of origin; therapeutic stress which is more related to the professional role where the stress from ethical dilemmas tend to occur; gender of client; gender of therapist; and tolerance for ambiguity, which has not been studied with attitudes of nonsexual behaviors but has been found in previous research to be a moderator variable for stress.
CHAPTER III

METHODOLOGY

The purpose of this chapter is to present a description of the methodology which was utilized to conduct this study. There are seven sections in this chapter: Population, Sample, Instruments, Data Collection Procedures, Research Design, and Statistical Analysis.

Population

The population for this study were counselors/human service professionals who were 1993 members of the American Counseling Association (ACA).

"The American Counseling Association is an organization of counseling and human development professionals who work in educational, health care, residential, private practice, community agency, government, and business and industry settings. The mission of ACA is to enhance human development throughout the life span and to promote the counseling and human development profession" (ACA, 1993, p.1).

The members not only differ somewhat by work settings but also by educational level, educational program, experience, and credentialing. The ACA granted
permission to the researcher for selection of a random sample of counselors from the national membership population for the purpose of this research study.

At the time of data collection, the total membership of ACA, including all 16 divisions, was 56,015 members. The membership was comprised of: 75% general membership, 23% students, and 2% retired and emeritus. Since reporting demographic information to ACA was optional for members, the following data were based on the information provided by approximately 74% of the members and may not total 100% due to rounding of the figures. Approximately 32% of the members indicated they were male and 68% female. The self-reported ethnic diversity was as follows: Caucasian, 90.4%; African American, 4.7%; Hispanic/Latino, 1.9%; Other, 1.4%; Asian, .9%; Native American, .7%. Members reported working in the following settings: 31% elementary, junior high, senior high, propriety, community college and vocational schools; 29% private practice/counseling; 17.6% colleges and universities; 11% community mental health agency; 3.2% rehabilitation programs/agencies; 3.5% government; 2.1% business and industry; .8% corrections; .8% military; .5% career development; .5% foundation. The reported ages ranged from 23 to 83 or older (this category, 83 or older, was labeled as born in 1920 or earlier). The highest degree completed was reported as follows: Doctorate, 17.3%; Education Specialist, 3.6%; Master’s, 66.9%; Bachelor’s, 10.7%; Associate or Certificate, .7%; and Other, .8%. The demographic information presented above was provided by the ACA membership office.
Sample

Members chosen for this study were currently (defined as within the last five years) providing counseling services to primarily adult clients. Given that ethical issues with adult clients seem to be different from those of non-adults, only ACA members who indicated that they were employed in a work setting primarily oriented toward working with adult clients were included in the sample. Also, because students, retirees and emeritus members may not have provided counseling services or may not have done so within the last 5 years, they were excluded from the study.

The number of subjects was determined through the application of the following criteria. Very large subject/variable ratios are needed to interpret canonical correlations. Stevens (1992) indicates that a subject/variable ratio of approximately 20:1 is needed to accurately interpret variates associated with the largest canonical correlation; 40:1 for interpreting the second largest canonical correlation. In this study a sample size of 700 counselors was selected. The expected return rate based on previous research is approximately 37% (Baer, 1991; Borys, 1988). Given this return rate the ratio of subjects to variable ratio was calculated to be approximately 20:1. This ratio provided for the most precise interpretation of the largest canonical correlation.

Seven hundred subjects, three hundred and fifty female and three hundred and fifty male counselors were randomly selected from the active membership of ACA after members in non-adult work settings, students, retirees, and emeritus were eliminated. The ACA computer program, which was utilized to select the random sample is located in Alexandria, Virginia and the
steps were as follows. First, the following ACA members were excluded: a) elementary, middle/junior high, secondary/high, vocational/technical, and parochial/propriety schools; b) professional and regular students c) foundation workers (i.e., grant writers for ACA) d) retired and emeritus members. Second, the population of interest was stratified by gender. A total count of members in the population of interest was recorded as 24,488 which is 44% of the total ACA population. There were 8,694 (35%) males and 15,794 (65%) females. Third, a program called "Random Select" was performed on the male and female populations, separately, to achieve 350 females and 350 males in the sample. Stratification was utilized to assure equal representation on the variable of gender for appropriate distribution of the Ethics Surveys. Fourth, the separate random samples of males and females were merged and sorted by zip codes for the printing of mailing labels for use by the researcher. The mailing list used in this study consisted of 690 members living in the United States and 10 members living in various foreign countries.

The 350 female and 350 male subjects were randomly assigned to one of four groups: 1) male counselors rating ethical behaviors with female clients; or 2) male counselors responding to behaviors with male clients; and 3) female counselors rating ethical behaviors with male clients; or 4) female counselors responding to behaviors with female clients. Within each of these four groups there were two sets of surveys randomly assigned to subjects. Two sets contained Ethics Survey A (female client) and two sets contained Ethics Survey B (male client); the Ethics Survey was always placed first in each survey booklet, the other questionnaires were randomly ordered. The four sets of
survey booklets were printed so that the questionnaire order was randomly changed to prevent a response bias occurring due to a specific order. The only difference between the A and B versions of the forms were the pronouns; on the "male client" forms the pronouns were masculine and on the "female client" forms the pronouns were feminine (see Table 1). The survey booklets were randomly assigned to subjects within each group through the employment of a random number table.

Table 1

Number of Subjects Randomly Assigned to Receive the Ethics Surveys A and B

<table>
<thead>
<tr>
<th>Subjects</th>
<th>ESA</th>
<th>ESB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female clients</td>
<td>Male clients</td>
</tr>
<tr>
<td>Male counselors</td>
<td>175</td>
<td>175</td>
</tr>
<tr>
<td>Female counselors</td>
<td>175</td>
<td>175</td>
</tr>
<tr>
<td>Totals</td>
<td>350</td>
<td>350</td>
</tr>
</tbody>
</table>

**Instruments**

The participants in this study were asked to complete five instruments: Demographic Information Questionnaire (DIQ), Ethics Survey A or B (ESA &
ESB) (adapted from Baer, 1991; Borys, 1988), Therapeutic Stresses Rating Scale (TSRS) (Hellman et al., 1986), the AT-20 Scale (AT-20) Ambiguity Tolerance Scale (MacDonald, 1970), and the Personal Characteristics Questionnaire (PCQ) (Miller, 1970). Each instrument is described below.

**Demographic Information Questionnaire (DIQ)**

This instrument was developed by the researcher and includes 13 items designed to gather occupational and socio-demographic information. The items included in this questionnaire represent characteristics that were similar to variables used in previous ethics studies investigating dual relationships and/or sexual intimacies with clients (Borys & Pope, 1989; Gibson & Pope, 1993; Thoreson et al., 1993). An item was developed for each characteristic of interest in this study.

This questionnaire contains six socio-demographic information items: gender, ethnic origin, age, marital status, sexual orientation, and highest degree completed. The remaining six items focus on occupational related information: licensure and certification, work setting, years of counseling experience, percentage of clients under 18 years of age and over 18 years of age, work isolation, and theoretical orientation.

The DIQ was given to a panel of four human service professionals who were current ACA members not included as respondents in this study to evaluate face validity before the packet was mailed to respondents. This panel included: an advanced graduate student majoring in Counselor Education working in private practice, a Licensed Professional Counselor (LPC) working in
the area of career development, an LPC working in the area of addictions, and a Counseling Psychologist practicing in a large university and in private practice.

**Ethics Survey (ESA and ESB)**

The Ethics Survey (ESA & ESB) used in this study was adapted by this researcher from two other measures which are described below. The Therapeutic Practices Survey (TPS), the original instrument, developed by Borys (1988), consists of two sections: Ethics and Practices. She investigated differences reported on attitudes of ethicality and actual self-report practices, and found that respondents endorsed behaviors as being more ethical than they did the frequency of the behaviors. An analysis of responses of the differences between the two forms (ethical behaviors and practices) showed that there were no significant differences. Darling (1991) also found similar results. Thoreson, et al. (1993) found that "overall, attitudes were found to be the best predictor of current sexual contact" (p. 433). Given these results and the insignificant reports of disparity between the reports and actual practices, the practices form was not utilized in this study (see Baer, 1991; Borys, 1988 for further information).

The Ethics section was developed for the purpose of collecting information on therapist attitudes toward differing dual relationship behaviors. Borys selected pertinent items based on a review of the clinical and research literature, and on malpractice and ethics complaint cases. For each dual relationship behavior a "brief, value-neutral descriptor" was used
Twenty items were selected for the Ethics section. The items were ordered so that the least threatening ones were presented first and the likelihood of social desirability sets were minimized. Three items are not related to nonerotic dual relationship behaviors. Two of the items chosen for each section were included for the purpose of evaluating social desirability responses (i.e., "Accepting a handshake offered by a client" and "Feeling sexually attracted to a client") (Borys, 1988, p. 62). Borys reasoned that since in previous research (Pope et al., 1987; Pope et al., 1986) subjects reported a high endorsement rate of these behaviors as being ethical, a low endorsement rate may indicate a bias in the respondents' answers. Borys also included one item on sexual intimacies with clients.

To minimize Type I error, which would be inflated if each ethical behavior was tested separately, Borys utilized a method of data reduction. A principal components factor analysis with a Harris-Kaiser oblique rotation was performed (Borys, 1988). Three factors were found for the Ethics section: Incidental Involvements (69.8% of the variance), Social/Financial Involvements (17% of the variance), and Dual Professional Roles (13.2% of the variance). All were loaded in a positive direction. On the Ethics section, participants are asked to indicate the degree to which each behavior is considered ethical. A 6-point Likert scale is applied as follows: 6 = "always ethical" to 1 = "never ethical," with another option of 0 = "not sure."

Baer (1991) adapted Borys' TPS (1988) for use in her research. She made four changes in the Ethics section. First, the Ethics section was renamed "Ethical Assessment Survey" (EAS); the format was changed, and the 6-point
Likert scale was retained. Second, three items were excluded ("Provided therapy to a then-current student or client," "Borrowed less than $5 from a client," and "Borrowed over $20 from a client"). She also divided one item into three separate items: "Providing individual therapy to a (1) friend, (2) lover or (3) relative" (Baer, 1991, p. 62.). A total of 21 items were used for the EAS.

Third, Borys assumed that respondents were answering items based upon the highest proportion of client gender reported on the demographic form. In other words, if 20% of the clients were reported to be male and 80% were reported to be female, Borys assumed that the respondent would complete the survey with a female client as a reference. Baer, however, built the sex of the client into her design. More specifically, Baer instructed the participants to complete the EAS section describing their interactions with either a "male" or "female" client.

Baers' (1991) approach was intended to reduce some of the error inherent in the previous design so that the researcher was not just assuming that the participant was filling out the survey based on a self-report of the proportion of male and female clients he/she counseled in the work setting. Last, two Ethics forms were printed: Form A for use with adult female clients and Form B which instructed the counselor to complete the survey considering behaviors with male clients.

For the present study, a combination of the Borys and Baer Ethics sections described above were utilized. The sections were renamed for use in the present study so that confusion does not occur with the original (Borys, 1988) and adapted (Baer, 1991) versions. The Ethics Survey: A (ESA) designated female clients and Ethics Survey: B (ESB) designated male clients.
Both Ethics Surveys (A & B) consisted of 22 items, the same as Baers’ study except the present researcher added one item “Provided therapy to a student or supervisee.” The directions and format were consistent with those in the original study (Borys, 1988) due to ease in understanding and clarity. Client gender was also built into the present research design as did Baers’ (1991) in order that 50% of the male and female counselors received a male client Ethics Survey and 50% received a female client Ethics Survey. The terms therapist, therapy and psychotherapy were changed to include counselor and counseling so as to more accurately reflect the professional identity of the respondents in the present study. Also the revised item (Baer, 1991) which was divided into three separate items (Providing therapy to a (1) friend (2) lover or (3) relative) was distributed throughout the instrument to avoid potential halo effects.

The ESA and ESB were scored by obtaining a total score for each respondents’ subscale (Incidental Involvements, Social/Financial Involvements, and Dual Professional Roles). “Not sure” responses were not included in the total scores and were coded as missing data because these responses would improperly influence the data interpretation.

Convergent validity of the TPS was demonstrated by the replication of the major findings in two later studies using surveys adapted from the original study (Baer, 1991; Darling; 1991). Permission was granted for adaption and use from Borys and Baer (Appendix H).
**Therapeutic Stresses Rating Scale (TSRS)**

The Therapeutic Stresses Rating Scale (TSRS) originated with Farber and Heifetz (1981). They developed a 37-item, 7-point Likert-type rating scale which lists work related stresses based on the input of psychiatrists, psychologists, and social workers. The scale is designed specifically for use with human service professionals to operationalize what they perceive as stressful in their therapeutic practice. A factor analysis and Varimax rotation of the rating scale revealed three factors. Factor I was labeled "Personal Depletion" and taps into the burnout construct of Maslach's (1976). Factor II was labeled "Therapeutic Relationship" and refers to the struggles of maintaining vulnerability and personal distance during therapy. Factor III relates to "Working Conditions" and consisted of items concerning work overload and professional doubt.

Hellman, Morrison, and Abramowitz (1987a) adapted the TSRS by adding items to the original factors personal depletion and therapeutic relationship. The Likert scale ranges from 1 = "Not a source of stress" to 7 = "Major source of stress." The scale asks respondents to indicate how much the listed issues are a source of stress in their practice. A factor analysis on the adapted TSRS yielded five factors (subscales) which accounted for 89% of the variance:

a) Factor I, Therapeutic Relationship (57.1% of the variance); b) Factor II, Scheduling, (12.3% of variance); c) Factor III, Professional Doubt (7.7% of variance); d) Factor IV, Work Overinvolvment, (6.4% of variance); and e) Factor V, Personal Depletion (5.4% of variance). All factors were loaded in a positive direction. Two of the factors in the original version (Personal Depletion
and Therapeutic Relationship) were congruous with the adapted versions factors.

The Heilman, Morrison, and Abramowitz (1987a) adaptation of the TSRS was utilized in the present study. The instrument was scored for each respondent by obtaining the total score for each factor. Scores can range from 26 to 182.

A replication study by Heliman et al., (1986) lends support for construct validity. Studying a different sample of psychologists, they identified factors consistent with those reported by Farber and Heifetz (1981). Heliman et al. (1986) indicate that the "demonstration of the empirical generalizability of the factor structure and of the relative importance of stressful therapeutic events argues for the usefulness of the Therapeutic Stress Rating Scale..." (p. 204). Permission was granted to use this scale by Heliman and Farber (Appendix H).

**AT-20 Scale (AT-20)**

The AT-20 Scale (MacDonald, 1970) is a 20-item scale measuring tolerance of ambiguity. This scale is formatted so that responders mark a "T" for true or an "F" for false before each item. It is scored for high ambiguity tolerance and yields one score. Persons low in tolerance tend to view situations as being black and white and display rigid coping behaviors. This variable was included for study based in previous research (Baer, 1991) which reported that there appears to be one or more variables in addition to stress that "may intervene concurrently to influence therapists' attitudes" (p. 123). She suggested that tolerance for ambiguity may be one of those variables.
Therefore, the present study investigated the role ambiguity tolerance plays in influencing counselor endorsement of the ethicality of dual relationship behaviors.

The AT-20 Scale was revised based on the original work of Rydell and Rosen (1966). The Rydell-Rosen Ambiguity Tolerance Scale is a 16-item scale with a true-false format. There were no reports of internal consistencies, however, the retest reliability was reported at .71 (p < .001) for one month and .57 (p < .001) for two months (Rydel & Rosen, 1966). Rydell (1966) also reported in a study of construct validity that there was a significant difference (p < .001) between subjects of high and low tolerance on mean semantic differential ratings of contradictory and non-contradictory adjective-noun concept combinations (p. 1303).

MacDonald (1970) revised the Rosen-Rydell instrument by adding two items from the California Psychological Inventory (Gough, 1957) and two items from the Barron’s Conformity Scale (Barron, 1953). Item correlations with total scores were strengthened from .21 -.70 to .36 -.73. The internal consistency was .86 (split-half with a Spearman-Brown correction) and .73 (using the Kuder-Richardson Formula 20). The split-half reliability coefficient rose from .64 to .86 by adding the four new items. Reliability was computed to be .63 (p < .01) for a 6 month interval.

Discriminant validity was assessed by MacDonald (1970) who found little correlation (.02, p < .01) between the AT-20 and the Crowne-Marlowe Social Desirability Scale (1960). This indicates that the AT-20 Scale was found to be free of a tendency for respondents to provide socially desirable responses.
Construct validity was also assessed in this study. He found a significant difference ($r = .33$, $p < .01$) between low and high ambiguity tolerance and performance of ambiguous tasks. Significant correlations were also found between the AT-20 Scale and the Rokeach Dogmatism Scale ($r = -.42$, $p < .01$), the Gough-Sanford Rigidity Scale ($r = -.41$, $p < .01$), the F Scale ($r = -.30$, $p < .01$), and church attendance ($r = -.24$, $p < .01$) which provides support for convergent validity. Permission for use of this scale was granted by Rydell, Psychological Reports, Duke University Press, Consulting Psychological Press, Inc., and Walls, of West Virginia University, for the late MacDonald (Appendix H).

**Personal Boundary (PBQ)/Personal Characteristics Questionnaire (PCQ)**

The Personal Boundary Questionnaire (PBQ) (Miller, 1970) was employed to provide a measure for the variable of differentiation of self. Dual relationships between counselors and clients, by their very nature, can involve an unclear or blurry sense of personal boundaries. The counselor needs to be vulnerable enough to be understanding of the client but differentiated enough to be separate and maintain his/her own ego boundaries. The PBQ consists of 41 statements rated on a 7-point Likert-type scale ($7 = "Strongly Agree"$ to $1 = "Strongly Disagree").

A factor analysis with Varimax rotations yielded two dimensions (Miller, 1970). The first factor, Boundary, includes items that differentiate self from other and the social environment. These items address keeping clear distances, time boundaries, and maintaining space. The second factor, Fusion, includes items that evaluate the degree to which the individual is
undifferentiated. In other words, what is the tendency for the respondent to blur personal boundaries and to be overinvolved and/or connected with others and with the environment. The Boundary-Fusion distinction is a dichotomous one that is present in therapeutic relationships and everyday interactions. This measure of differentiation was chosen because it was easy to understand, measured the two dimensions (Boundary and Fusion) of the differentiation variable, and required little time to complete.

The individual respondents total scores for each dimension were obtained for statistical analysis. Scores can range from 16 to 112 on the Boundary dimension and from 25 to 175 on the Fusion dimension. All items on the Fusion dimension loaded positively but, some items loaded negatively on the Boundary dimension and this was taken into account when the scores were calculated.

The PBQ has been used in over 40 studies (Miller, personal communication, February 1, 1993). Convergent validation of this construct has been developed through the positive correlation with other measures assessing a similar construct but with different target populations, such as teachers as well as experienced and student therapists (Greene & Geller; 1980 Morrison, 1975). Correlations were significant between the PBQ and the Classroom Boundary Questionnaire ($r = .44, \ p < .05$) and the PBQ and the Therapist Termination Questionnaire ($r$ not specified in study, $p < .05$). The Boundary dimension was reported to share some overlapping variance with the Social Desirability Scale (Crowne & Marlowe, 1960) (Miller, 1970). Discriminant validity was demonstrated by Molin (1979/1980). In Molins’ study neither anxiety nor
tolerance of ambiguity was significantly correlated with the Boundary or Fusion factors. Construct validity is on-going with several studies yielding findings of this measure’s ability to discriminate on the Boundary-Fusion dimensions based on populations of teachers, therapists, psychiatrists, and adolescent drug abusers and their families (Greene & Geller, 1980; Hellman, Morrison, & Abromowitz, 1987b; Morrison, 1985; Weidman, 1983).

In an earlier version of the PBQ the title of "Personal Characteristics Questionnaire" (PCQ) was used. In the present study the title of Personal Characteristics Questionnaire was also used to minimize response bias. Permission to use the PCQ was granted by Miller (Appendix H).

**Data Collection Procedures**

Selected procedures were followed in this study to help control for representativeness, measurement error, and data accuracy. First, a conscientiously structured process for selecting a sample representative of the population was implemented by paying particular attention to choosing the population of interest and using a randomization method to select the sample from this population. Next, the Total Design Method (TDM) of survey research by Dillman (1978) was utilized to provide this study with a systematic data collecting method. The TDM helps to maximize response quality and quantity from the respondent. This method employs a precise mailing and follow-up procedure which was followed in this study to maximize the return rate.

Each of the 700 subjects received, through a first class mailing, survey contents assigned according to gender of therapist and client. The mailing
included: a one-page cover letter; the Ethics Survey A or B (ESA or ESB); an ambiguity tolerance scale (AT-20 Scale); the Therapeutic Stresses Rating Scale (TSRS); the Personal Characteristics Questionnaire (PCQ); and the Demographic Information Questionnaire (DIQ). Four different sets of survey booklets were printed with the questionnaire order randomly changed to prevent a response bias occurring due to a specific order. Two sets of surveys contained Ethics Survey A (female client) and two sets contained Ethics Survey B (male client). The Ethics Survey (A or B) was arranged first in all booklets since it was the measurement of the dependent variable and deemed to be the most necessary information in the booklet. The DIQ was arranged on the last page in all booklets since it was information that respondents were likely to answer.

In line with the TDM the mailing included two other elements. First, a business reply mail envelope, professionally printed with the address of the University and the return address of the department, was included for the return of the completed questionnaires. The cover letter stressed that respondents not place their name or other identifying information on the return envelope or questionnaires so that they could return the packet anonymously. Second, a pre-paid commemorative, professionally printed, postcard was included for the respondent to return separately from the survey packet (Appendix E). Each mailing utilized a different commemorative stamp on the postcards. The commemorative postcards were utilized to encourage respondents to read them and to boost the return rate (Dillman, 1978). They also served as an indicator regarding the mailing to which the respondent was replying.
The postcard provided in the first and second mailing allowed the respondents to check a box if they wanted to receive a written summary of the results and also asked them to sign their name on a line provided indicating that they returned their survey. This procedure was designed to maintain the respondents’ anonymity on the questionnaires while providing the researcher a means to utilize follow-up procedures with participants who did not return their packets within a reasonable period of time (Dillman, 1978). Anonymity was considered necessary to secure candid responses from subjects. No coding was used on the questionnaires until they were completed by the respondent and returned to the researcher due to the sensitive nature of the topic. The completed questionnaires were coded numerically and dated as they were received so that promptness of response could be analyzed. No information was used from the return envelopes; they were destroyed.

To aid in increasing the response rate, the guidelines for the TDM follow-up procedures were followed. Seven days from the original mailing date a follow-up commemorative postcard, was sent via first class mail to all participants (Appendix F). It thanked those who returned their completed questionnaires and served as a reminder to those who had not yet returned their completed questionnaires (Dillman, 1978). Three weeks after the original mailing date, a follow-up packet was sent, via first class mail, to those who did not return the postcard in the original mailing. The packet consisted of a different cover letter (Appendix H), however, the rest of the packet was in the same random order sent in the original mailing. Six weeks from the original mailing date, a third follow-up letter (Appendix I), the DIQ and business reply
mail envelope was mailed to all non-respondents. This procedure was used to
provide a means to observe any significant differences between the non-
respondents to respondents (early and late) on demographic variables.

Slightly different procedures were necessary for the mailing and return of
the foreign surveys. The survey packets were set up exactly like the U. S.
packets with the exception of three points. First, a regular #10 envelope was
self-addressed to the department. This was used instead of the business reply
mail envelope which postage was valid only if mailed within the U. S. Since
respondents had to buy their own country’s postage to send mail to the U. S.
pre-paid postage could not be used. Second, a red slip of paper was inserted
in front of the return envelope which gave instructions on return mailing
procedures (Appendix J). The note indicated that since pre-paid postage could
not be utilized due to the different postal systems, the respondent had to buy
postage to return the survey and the postcard. It was also noted that the
respondents would be reimbursed for the postage cost. Third, the postcard
was modified at the bottom with a line for postal reimbursement cost so the
researcher would know the amount spent on postage and to whom the
reimbursement should be sent (Appendix K). This arrangement still allowed the
survey packet to be sent anonymously.

Data were collected between the dates of May 7, 1993 and August 23,
1993. A written summary of the research results were mailed to 412
respondents who requested a summary by checking the appropriate box on the
postcard.
**Research Design**

A descriptive, cross-sectional, correlational research design was selected for this study (Ary, Jacobs and Razavieh, 1979; Gay, 1981; Spector, 1981). Given that some variables in this study have not been investigated in relation to ethics and/or have not been examined previously with this population, it was thought that this research design would provide a means to identify how the predictor variables relate to the criterion. More specifically, this design yields data to investigate the relationship between ethical behaviors and a variety of counselor characteristics.

This research design provides for the collection of data through the use of questionnaires. Self-report instruments were employed in this study because: a) they are the most extensively used data collection method in the area of ethical behavior, b) respondents can reply to sensitive questions in a way that anonymity can be preserved, which is helpful in obtaining a more reliable response, and c) they are less time consuming and expensive than either interview or observation methods (Dillman, 1978).

**Statistical Analysis**

Canonical correlation was conducted in order to investigate the relationship of the overall counselor endorsement of ethical behaviors to therapeutic stress, personal boundary tendencies, tolerance for ambiguity, gender of counselor, and gender of client. A canonical correlation "investigates the degree of relationship between two sets of variables" (Thompson, 1984, p. 14). This analysis, in particular, was selected to analyze the variance explained
in the three scales of the dependent variable set (endorsement of ethical behaviors) by the independent variable set (therapeutic stress, personal boundary tendencies, tolerance for ambiguity, and gender). In utilizing this multivariate analysis, the three scales on the dependent variable set (incidental, social/financial, and dual professional relationships) were placed in the analysis simultaneously to observe the variance explained in the overall ethicity endorsement. Three multiple regression analyses were employed after the multivariate analysis. These analyses were utilized to separately investigate the relationship of each of the dependent variables to the linear combination of the independent variables. The Statistical Package for Social Sciences (SPSS/PC+, Version 5, 1992a; SPSS/PC+, Version 5, 1992b; SPSS for Windows, Release 6, 1993a; SPSS for Windows, Release 6, 1993b) were used to analyze the data.
CHAPTER IV
RESEARCH RESULTS

The purpose of this study was to examine the relationship of dual role behaviors endorsed by counselors as ethical to several counselor characteristics and gender of client. Specifically, the predictive variables were therapeutic stress, tolerance for ambiguity, personal boundary preference, gender of counselor, and gender of client.

This chapter is divided into five major sections. The first two sections describe the response rate and the representativeness of the sample. Third, a description of the sample is provided. Fourth, the reliability of each instrument is reported. The next section examines the principal components analysis to extract factors of the ESA/B. Last, the results are presented by research question.

Response Rate of the Sample

Data for the present study were collected from counselors and other mental health professionals who were members of a national organization, the American Counseling Association (ACA). The size of the randomly selected sample was 700. The sample was stratified by gender; 350 male and 350 female counselors. Each survey packet included a postcard which was to be
returned to the researcher by the respondent, under separate cover, for follow-up purposes.

A total of 485 (69.3%) responses were received. Four hundred and seventy-four surveys (64.1%) were returned; 326 (46.6%) responded to the first mailing and 148 (21.1%) to the second. From the 485 survey packets received, 23 surveys were either incomplete or not useable, 2 surveys were undeliverable by the postal service, and 11 respondents indicated by writing on their returned postcards that they were not qualified to participate in this research and, therefore, were withdrawing from the study. Respondents who either sent incomplete or unusable surveys or withdrew from the study by postcard gave several reasons: Three were not members of ACA, three were not currently providing counseling, three provided counseling for children only, one cited personal reasons, and one was retired. The reasons for not utilizing the 23 surveys were: eight surveys were blank, six surveys were incomplete, three respondents were not providing counseling, three respondents were counseling children only, one respondent was not an ACA member, one survey was received after the cut-off date, and one respondent sent back other material instead of the survey.

Therefore, for data analysis, a total of 449 (64.1%) surveys were utilized. Table 2 provides a summary of the response rates for each counselor-client grouping. The number of responses for the four groups were as follows: female counselors with female clients, 115 (16.4%); female counselors with male clients, 121 (17.2%); male counselors with female clients, 104 (14.8%); and male counselors with male clients was, 109 (15.5%).
Table 2

Number of Respondents by Gender of Counselor and Client

<table>
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<tr>
<th>Gender of Client</th>
<th>Gender of Counselor</th>
<th>Sent</th>
<th>Rec'd</th>
<th>%</th>
<th>Sent</th>
<th>Rec'd</th>
<th>%</th>
<th>Sent</th>
<th>Rec'd</th>
<th>%</th>
<th>Total</th>
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<tr>
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<td></td>
<td>A</td>
<td>87</td>
<td>51</td>
<td>11.4</td>
<td>88</td>
<td>64</td>
<td>14.2</td>
<td>87</td>
<td>47</td>
<td>10.5</td>
<td>88</td>
<td>52</td>
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</table>
Four hundred and forty-three postcards were returned by respondents who completed the survey (not including the 11 who withdrew from the study by postcard). Since no coding was utilized prior to receiving completed surveys, it was impossible to determine how many respondents may not have returned the postcard after completing the survey and how many counselors may have returned the postcard without returning a completed survey. However, this did not seem to have any adverse affect on the study since the postcard was utilized for the sole purpose of providing information for follow-up mailings.

**Representativeness of the Sample**

Of the returned surveys, 449 (64.1%) were utilized for data analysis. Dillman (1978) stated that "response rates to mail questionnaires are usually lower than those obtained by either of the interview methods..." such as face-to-face or telephone interviewing (p. 51). The response rate of the present research was moderately higher than those achieved in similar research surveys. For example, Borys' (1988) response rate was 49% and Baers' (1991) was 38%. In addition, other similar research studies have reported response rates ranging from 32% to 59% (e.g., Gibson & Pope, 1993; Pope et al., 1987; Sharkin & Birky, 1992; Thoreson et al., 1993).

To further investigate the representativeness of this sample and explore the generalizability of this study to the target population, two procedures were performed. First, chi-square and t-test analyses were utilized to ascertain whether early and late respondents were statistically different on eight variables:
marital status, ethnicity, sexual orientation, degree, credential status, work setting, theoretical orientation, and social isolation. The results of the chi-square tests for independence for these selected demographic variables indicated acceptance of the null hypotheses which states that respondent group (early vs. late) is independent of each of the eight demographic variables. Therefore, no statistically significant associations were found between the early and late respondents among any of the selected demographic variables (Table 3).

Table 3
Chi-squares for Early to Late Respondents by Selected Demographic Characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>$X^2$</th>
<th>df</th>
<th>$p^*$</th>
</tr>
</thead>
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<tr>
<td>Demographic Characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td>449</td>
<td>3.92</td>
<td>3</td>
<td>.27</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>448</td>
<td>2.26</td>
<td>3</td>
<td>.52</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>447</td>
<td>0.26</td>
<td>1</td>
<td>.61</td>
</tr>
<tr>
<td>Degree</td>
<td>449</td>
<td>0.57</td>
<td>3</td>
<td>.90</td>
</tr>
<tr>
<td>Credential Status</td>
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<td>0.21</td>
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<td>.65</td>
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<td>Work Setting</td>
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<td>6.96</td>
<td>6</td>
<td>.32</td>
</tr>
<tr>
<td>Theoretical Orientation</td>
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<td>.60</td>
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<tr>
<td>Social Isolation</td>
<td>449</td>
<td>.13</td>
<td>3</td>
<td>.99</td>
</tr>
</tbody>
</table>

*p < .05
A t-test comparing early respondents and late respondents by age (t(439) = -1.06, p < .291) and years of experience (t(444) = .01, p < .990) indicated no statistically significant difference between the early and late respondents (Table 4).

Table 4

**T-test Comparisons Between Early and Late Respondents**

*by Age and Years of Experience*

<table>
<thead>
<tr>
<th>Variables</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td>-1.06</td>
</tr>
<tr>
<td>Early Respondents</td>
<td>308</td>
<td>44.8377</td>
<td>8.912</td>
<td></td>
</tr>
<tr>
<td>Late Respondents</td>
<td>133</td>
<td>45.8195</td>
<td>9.029</td>
<td></td>
</tr>
<tr>
<td>Years of Experience</td>
<td></td>
<td></td>
<td></td>
<td>.01</td>
</tr>
<tr>
<td>Early Respondents</td>
<td>312</td>
<td>9.7628</td>
<td>7.195</td>
<td></td>
</tr>
<tr>
<td>Late Respondents</td>
<td>134</td>
<td>9.7537</td>
<td>6.487</td>
<td></td>
</tr>
</tbody>
</table>

*p < .05

Second, chi-square and t-test analyses were utilized to determine whether respondents of completed surveys and nonrespondents (those who returned only the DIQ in response to the third follow-up mailing) differed significantly. The respondents and nonrespondents were analyzed on the following eight variables: marital status, ethnicity, sexual orientation, degree, credential status, work setting, theoretical orientation, and social isolation. The
results of the chi-square tests of independence indicated acceptance of the null hypotheses which states that respondent group (respondent vs. nonrespondent) is independent of each of the eight demographic variables (Table 5).

Table 5

Chi-squares for Respondents of Survey to Nonrespondents by Demographic Characteristics.

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>$X^2$</th>
<th>df</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic Characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td>527</td>
<td>1.73</td>
<td>3</td>
<td>.63</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>526</td>
<td>2.78</td>
<td>3</td>
<td>.43</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>524</td>
<td>0.67</td>
<td>1</td>
<td>.76</td>
</tr>
<tr>
<td>Degree</td>
<td>527</td>
<td>4.70</td>
<td>3</td>
<td>.19</td>
</tr>
<tr>
<td>Credential Status</td>
<td>526</td>
<td>0.77</td>
<td>1</td>
<td>.38</td>
</tr>
<tr>
<td>Work Setting</td>
<td>525</td>
<td>9.42</td>
<td>6</td>
<td>.15</td>
</tr>
<tr>
<td>Theoretical Orientation</td>
<td>521</td>
<td>1.58</td>
<td>4</td>
<td>.81</td>
</tr>
<tr>
<td>Social Isolation</td>
<td>526</td>
<td>2.97</td>
<td>3</td>
<td>.40</td>
</tr>
</tbody>
</table>

*p < .05.

The t-test analysis comparing respondents to nonrespondents on age ($t(514) = 1.56, p < .119$) indicated no statistically significant differences (Table 6). However, these two groups did differ significantly on years of experience ($t(96.31) = 2.43, p < .017$). The mean years of experience was significantly
higher for the nonrespondents (Table 6). However, since the nonrespondents have a mean age of approximately two years older than the respondents, it would be expected that they would also report approximately two more years of counseling experience than the respondents.

Table 6

T-test Comparisons Between Respondents of Survey and Nonrespondents by Age and Years of Experience

<table>
<thead>
<tr>
<th>Variables</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographic Characteristics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respondents</td>
<td>441</td>
<td>45.1338</td>
<td>8.948</td>
<td>1.56</td>
</tr>
<tr>
<td>Nonrespondents</td>
<td>75</td>
<td>46.9067</td>
<td>9.911</td>
<td></td>
</tr>
<tr>
<td>Years of Experience</td>
<td></td>
<td></td>
<td></td>
<td>2.43*</td>
</tr>
<tr>
<td>Respondents</td>
<td>446</td>
<td>9.7601</td>
<td>6.982</td>
<td></td>
</tr>
<tr>
<td>Nonrespondents</td>
<td>78</td>
<td>12.2179</td>
<td>8.437</td>
<td></td>
</tr>
</tbody>
</table>

*p < .05.

It can be concluded from the results of these analyses that the early and late respondents in this research were similar on the demographic information collected. The respondents and nonrespondents were also similar on the demographic information except for the number of years providing counseling services since the completion of training. No data have been collected in the American Counseling Association with regard to the years of experience
members have in providing counseling, consequently, it is not possible to compare data collected in this study with those of the organization. Therefore, the sample of 449 counselors may not represent a true reflection of the total ACA population and care should be taken in the interpretation and generalization of the results.

**Description of the Sample**

The characteristics of the sample which are based on the information collected from the DIQ are reported in this section. It is important to note that data in the following tables do not always total 449, as some respondents did not answer all items.

**Gender**

There were 236 (52.6%) female counselors and 213 (47.4%) male counselors who completed useable surveys. Of the 449 useable surveys returned, 214 (47.7%) were counselors responding with female client forms and 235 (52.3%) were counselors responding with male client forms (refer back to Table 2).

**Ethnic Origin**

The majority of the respondents in this sample, 399 (88.9%), reported ethnic origin as Caucasian. Thirteen (2.9%) respondents identified as African American, six (1.3%) as Asian, ten (2.2%) as Native American, 12 (2.7%) as Hispanic and eight (1.8%) as "Other" (Table 7). Those responding to the
"Other" category were asked to specify their ethnic origin in the blank provided. The responses in the "Other" category included mixed ethnicities and Jewish.

Table 7

Respondents' Ethnic Origin by Frequency and Percent

<table>
<thead>
<tr>
<th>Ethnic Origin</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>13</td>
<td>2.9</td>
<td>2.9</td>
</tr>
<tr>
<td>Asian</td>
<td>6</td>
<td>1.3</td>
<td>4.2</td>
</tr>
<tr>
<td>Native American</td>
<td>10</td>
<td>2.2</td>
<td>6.4</td>
</tr>
<tr>
<td>Hispanic</td>
<td>12</td>
<td>2.7</td>
<td>9.1</td>
</tr>
<tr>
<td>Caucasian</td>
<td>399</td>
<td>89.1</td>
<td>98.2</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>1.8</td>
<td>100.0</td>
</tr>
</tbody>
</table>

n=448

Age

The average age for the respondents was 45 with a standard deviation of 8.9. The median was also 45 and the distribution was multimodal; the modes being 43 and 46. The range for the total group was from 25 to 88 years. Most respondents, 50%, were between the ages of 40 and 50, with 25% falling between the ages of 25 through 39 and between the ages of 51 and older. Table 8 provides the frequencies and percentages for all respondents by age.
Examination of this data by gender revealed that male counselors had a mean age of 46 and a range from 27 to 88 years. The women counselors had a mean age of 44 and a range from 25 to 72 years.

Table 8

Respondents’ Age by Frequency and Percent

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 and older</td>
<td>9</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>55 - 64 years</td>
<td>56</td>
<td>12.7</td>
<td>14.7</td>
</tr>
<tr>
<td>45 - 54 years</td>
<td>157</td>
<td>35.6</td>
<td>50.3</td>
</tr>
<tr>
<td>35 - 44 years</td>
<td>166</td>
<td>37.7</td>
<td>88.0</td>
</tr>
<tr>
<td>25 - 34 years</td>
<td>53</td>
<td>12.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

n = 441

Marital Status

Of the 449 respondents, 351 (78.2%) indicated that they were married, partnered, or cohabitating. Forty-five (10%) of the respondents reported having never married and 53 (11.8%) reported either being divorced, separated or widowed (Table 9).
Table 9

Respondents' Marital Status by Frequency and Percent

<table>
<thead>
<tr>
<th>Marital Status Percent</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never Married</td>
<td>45</td>
<td>10.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Married/Partnered</td>
<td>329</td>
<td>73.3</td>
<td>83.3</td>
</tr>
<tr>
<td>Cohabitating</td>
<td>22</td>
<td>4.9</td>
<td>88.2</td>
</tr>
<tr>
<td>Divorced</td>
<td>45</td>
<td>10.0</td>
<td>98.2</td>
</tr>
<tr>
<td>Separated</td>
<td>4</td>
<td>0.9</td>
<td>99.1</td>
</tr>
<tr>
<td>Widowed</td>
<td>4</td>
<td>0.9</td>
<td>100.0</td>
</tr>
</tbody>
</table>

n = 449

Sexual Orientation

In this survey, sexual orientation was measured on a five-point scale. The majority of the 447 counselors and therapists who responded to this item, reported being exclusively heterosexual; 388 (86.8%). The remaining respondents indicated their sexual orientation as follows: 29 (6.5%) heterosexual with homosexual experiences; 5 (1.1%) bisexual; 11 (2.5%) homosexual with heterosexual experiences, and; 14 (3.1%) exclusively homosexual (Table 10).
Table 10

Respondents' Sexual Orientation by Frequency and Percent

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusively Heterosexual</td>
<td>388</td>
<td>86.8</td>
<td>86.8</td>
</tr>
<tr>
<td>Heterosexual with homosexual experiences</td>
<td>29</td>
<td>6.5</td>
<td>93.3</td>
</tr>
<tr>
<td>Bisexual</td>
<td>5</td>
<td>1.1</td>
<td>94.4</td>
</tr>
<tr>
<td>Homosexual with heterosexual experiences</td>
<td>11</td>
<td>2.5</td>
<td>96.9</td>
</tr>
<tr>
<td>Exclusively Homosexual</td>
<td>14</td>
<td>3.1</td>
<td>100.0</td>
</tr>
</tbody>
</table>

n = 447

Highest Degree

Respondents were requested to indicate the highest educational degree achieved. Nearly all of the respondents had received graduate degrees (n = 436, 97.1%) and the majority of the degrees were at the Master's level (n = 310, 69%) (Table 11). Only nine respondents received a Bachelor's degree and one an Associate degree. Three respondents wrote in responses difficult to categorize, such as "Certificate of Advanced Study." These responses were entered in the "Other" category.
Table 11

Respondents' Highest Degree by Frequency and Percent

<table>
<thead>
<tr>
<th>Highest Degree</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctorate</td>
<td>114</td>
<td>25.4</td>
<td>25.4</td>
</tr>
<tr>
<td>Education Specialist</td>
<td>12</td>
<td>2.7</td>
<td>28.1</td>
</tr>
<tr>
<td>Master's</td>
<td>310</td>
<td>69.0</td>
<td>97.1</td>
</tr>
<tr>
<td>Bachelor's</td>
<td>9</td>
<td>2.0</td>
<td>99.1</td>
</tr>
<tr>
<td>Associate/Certificate</td>
<td>1</td>
<td>0.2</td>
<td>99.3</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0.7</td>
<td>100.0</td>
</tr>
</tbody>
</table>

n = 449

Credential Status

Respondents were asked whether they held a state or national license, registration or certificate. In this sample, twice as many respondents were licensed, registered, or certified (299, 66.7%) than not (149, 33.3%) (Table 12).
Table 12

Respondents' Credential Status by Frequency and Percent

<table>
<thead>
<tr>
<th>Credential Status</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>299</td>
<td>66.7</td>
<td>66.7</td>
</tr>
<tr>
<td>No</td>
<td>149</td>
<td>33.3</td>
<td>100.0</td>
</tr>
</tbody>
</table>

n=448

Note. Credential Status refers to whether respondent possessed a license, registration, or certificate to provide counseling or therapy.

Almost half of the respondents indicated that their field of credential was counseling (n=206, 46.6%) (Table 13). Psychology was the second most represented field (n=32, 7.2%), followed by social work, marriage and family, and substance abuse (each n=15, 3.4%). The least represented fields were rehabilitation (n=6, 1.4%), nursing (n=3, 0.7%), and pastoral counseling (n=1, 0.2%).
Table 13

Respondents' Field of License, Certification, or Registration by

Frequency and Percent

<table>
<thead>
<tr>
<th>Field</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>206</td>
<td>46.6</td>
<td>46.6</td>
</tr>
<tr>
<td>Psychology</td>
<td>32</td>
<td>7.2</td>
<td>53.8</td>
</tr>
<tr>
<td>Social Work</td>
<td>15</td>
<td>3.4</td>
<td>57.2</td>
</tr>
<tr>
<td>Marriage and Family</td>
<td>15</td>
<td>3.4</td>
<td>60.6</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>15</td>
<td>3.4</td>
<td>64.0</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>6</td>
<td>1.4</td>
<td>65.4</td>
</tr>
<tr>
<td>Nursing (R.N.)</td>
<td>3</td>
<td>0.7</td>
<td>66.1</td>
</tr>
<tr>
<td>Pastoral</td>
<td>1</td>
<td>0.2</td>
<td>66.3</td>
</tr>
<tr>
<td>No Licensure Status</td>
<td>149</td>
<td>33.7</td>
<td>100.0</td>
</tr>
</tbody>
</table>

n=442

Work Setting

The majority of the survey respondents (n=397, 88.6%) reported they worked primarily in four settings: Private practice (n=205, 45.8%); colleges and universities (n=104, 23.2%); community mental health centers (n=59, 13.2%), and; rehabilitation agencies (n=29, 6.5%) (Table 14). The remaining respondents (n=51, 11.4%) indicated they worked in settings such as government, corrections, and business and industry.
Table 14

Respondents' Work Setting by Frequency and Percent

<table>
<thead>
<tr>
<th>Work Setting</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>College/Univ.</td>
<td>104</td>
<td>23.2</td>
<td>23.2</td>
</tr>
<tr>
<td>Private Practice</td>
<td>205</td>
<td>45.8</td>
<td>69.0</td>
</tr>
<tr>
<td>Community MHC</td>
<td>59</td>
<td>13.2</td>
<td>82.1</td>
</tr>
<tr>
<td>Rehab. Agency</td>
<td>29</td>
<td>6.5</td>
<td>88.6</td>
</tr>
<tr>
<td>Career Development</td>
<td>5</td>
<td>1.1</td>
<td>89.7</td>
</tr>
<tr>
<td>Government</td>
<td>13</td>
<td>2.9</td>
<td>92.6</td>
</tr>
<tr>
<td>Corrections</td>
<td>3</td>
<td>0.7</td>
<td>93.3</td>
</tr>
<tr>
<td>Business/Industry</td>
<td>13</td>
<td>2.9</td>
<td>96.2</td>
</tr>
<tr>
<td>Elem. - High School</td>
<td>6</td>
<td>1.3</td>
<td>97.5</td>
</tr>
<tr>
<td>Military</td>
<td>8</td>
<td>1.8</td>
<td>99.3</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0.7</td>
<td>100.0</td>
</tr>
</tbody>
</table>

n=448

Note. 'Other' was added to account for medical settings.

Years of Experience

The average years of experience for the respondents was 10 with a standard deviation of 7. The range of experience in counseling was from 1 to 40 years. The distribution was multimodal; the modes being 2 and 10.

Approximately 50 percent of the survey respondents indicated 5 to 14 years of experience (Table 15). Male counselors had an average of 11.5 years
of experience and a range of 1 to 40 years. Whereas, female counselors had an average of 8 years of experience and a range of 1 to 27 years of experience.

Table 15

Respondents: Years of Experience by Frequency and Percent

<table>
<thead>
<tr>
<th>Years of Experience</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 - 40</td>
<td>3</td>
<td>0.7</td>
<td>0.7</td>
</tr>
<tr>
<td>30 - 34</td>
<td>3</td>
<td>0.7</td>
<td>1.4</td>
</tr>
<tr>
<td>25 - 29</td>
<td>12</td>
<td>2.7</td>
<td>4.1</td>
</tr>
<tr>
<td>20 - 24</td>
<td>27</td>
<td>6.0</td>
<td>10.1</td>
</tr>
<tr>
<td>15 - 19</td>
<td>61</td>
<td>13.7</td>
<td>23.8</td>
</tr>
<tr>
<td>10 - 14</td>
<td>106</td>
<td>23.8</td>
<td>47.6</td>
</tr>
<tr>
<td>5 - 9</td>
<td>111</td>
<td>24.9</td>
<td>72.5</td>
</tr>
<tr>
<td>1 - 4</td>
<td>123</td>
<td>27.5</td>
<td>100.0</td>
</tr>
</tbody>
</table>

n=446.

Note. For the purposes of this study, experience between 0 and 1 year was coded as 1 year.

Theoretical Orientation

Respondents were provided with five options to indicate which theoretical orientation most influenced their counseling/therapy: Behavioral, cognitive, humanistic (which included gestalt, existential, Rogerian), psychodynamic, and
other. Respondents were instructed to fill in their orientation if they chose "other".

Thirty percent (n=134) of the respondents indicated that humanistic orientations were most influential in their practices, 26.2 percent (n=117) indicated cognitive, 12.3 (n=55) percent indicated psychodynamic, and 10.1 (n=45) percent indicated behavioral (Table 16). The "other" category included theoretical orientations such as systems, feminist, Jungian, brief, primal integration, Adlerian, eclectic, and neural linguistic programming.

Table 16

Respondents' Theoretical Orientation by Frequency and Percent

<table>
<thead>
<tr>
<th>Theoretical Orientation</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral</td>
<td>45</td>
<td>10.1</td>
<td>10.1</td>
</tr>
<tr>
<td>Cognitive</td>
<td>117</td>
<td>26.2</td>
<td>36.3</td>
</tr>
<tr>
<td>Humanistic</td>
<td>134</td>
<td>30.0</td>
<td>66.4</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>55</td>
<td>12.3</td>
<td>78.7</td>
</tr>
<tr>
<td>Other</td>
<td>98</td>
<td>21.4</td>
<td>100.0</td>
</tr>
</tbody>
</table>

n=446

Social Isolation

A majority of the 449 respondents indicated that they did not feel isolated or felt mildly isolated in their work setting (n=316, 70.4%). However, almost
30% (n = 133) indicated that they felt moderately or extremely isolated (Table 17).

Table 17

Respondents’ Social Isolation by Frequency and Percent

<table>
<thead>
<tr>
<th>Social Isolation</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely Isolated</td>
<td>27</td>
<td>6.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Moderately Isolated</td>
<td>106</td>
<td>23.6</td>
<td>29.6</td>
</tr>
<tr>
<td>Mildly Isolated</td>
<td>151</td>
<td>33.6</td>
<td>63.3</td>
</tr>
<tr>
<td>Not Isolated</td>
<td>165</td>
<td>36.7</td>
<td>100.0</td>
</tr>
</tbody>
</table>

n = 449

In summary, a profile of the study sample revealed that the majority of respondents were Caucasian, exclusively heterosexual, and married or partnered. The average age of respondents was 45 years and the average years of experience was 10 with males being slightly older and more experienced. Most respondents reported working either in private practice or in a college/university setting. Two-thirds of the respondents indicated that they held a state or national license, registration or certificate. A majority reported their highest degree attained was the Master’s degree, with the Doctorate second in frequency. The two most frequently endorsed theoretical orientations were humanistic and cognitive. In addition, most respondents reported feeling either mildly isolated in their workplace or not isolated at all.
Reliability of the Independent Measures

A reliability check was performed on each of the independent measures: the Therapeutic Stresses Rating Scale (TSRS), the AT-20, and the Personal Characteristics Questionnaire (PCQ). The generally accepted range of reliability is from .70 (Shertzer & Linden, 1979) to .80 (Nunnally, 1978) depending on the length, purpose and other relevant information. The scores for each of these instruments were obtained by calculating a total score for each respondents’ subscale and are reported below.

Reliability of the TSRS

The TSRS was designed to measure stress experienced by mental health workers in their work environment. It consists of 26 items rated on a seven-point Likert scale.

A Cronbach’s alpha coefficient was computed for the total instrument and each subscale (factor). The total alpha coefficient for the TSRS was .92. For each subscale, the alpha coefficients were as follows: Therapeutic Relationship, .90; Scheduling Difficulties, .73; Professional Doubt, .80; Work Overinvolvement, .72, and; Personal Depletion, .75.

Reliability of the PCQ

The PCQ contains 41 items rated on a seven-point Likert scale. It was designed to measure personal boundaries tendencies.

The Cronbach alpha coefficient for the PCQ was .58. The Boundary and Fusion factors had alpha coefficients of .68 and .72, respectively. These
coefficients were similar to those found by Miller (1970) who performed a split-half reliability with the Spearman-Brown correction on the two factors. In his study, the Boundary factor had a split-half reliability of .61 and the Fusion factor had a reliability of .71.

**Reliability of the AT-20**

The AT-20 consists of 20 items with answer choices of true or false. It was designed to measure ambiguity tolerance. A split-half reliability using the Spearman-Brown prophecy formula was performed on this instrument. The reliability for this sample, .67, was lower than expected given that MacDonald (1970) reported a split-half reliability with the Spearman-Brown correction of .86 and a Kuder - Richardson 20 (KR 20) of .73.

**Reliability of the Dependent Measures**

A reliability check was also performed on the dependent measure: the Ethics Survey (Form A and B combined). Only 20 items of the 22-item scale were utilized for analyses; excluding items 9 and 12 which were included as social bias indicators. In addition, items that respondents endorsed as "not sure" were omitted due to its conceptual difference from the other responses. The factor scores for this instrument were obtained by calculating a total score for each respondents' subscale and are reported below.
Reliability of the ES (A and B)

The Ethics Survey, utilizing the three-factor solution from Borys' (1988) research, had a Cronbach alpha coefficient of .84. In addition, the alpha coefficients calculated for each factor are as follows: Incidental Involvements, .60; Social/Financial Involvements, .76, and; Professional Dual Roles, .72.

Factor Analysis of the ES (A and B)

The ES (A and B) consisted of 22 items which described dual relationship involvements with clients. These items were rated on a Likert-type scale from 5, always ethical, to 1, never ethical, and, 0, not sure.

The reliability coefficients reported for the ES (for this sample) were based on the factor analysis performed by Borys (1988). Baer (1991) also utilized these factors in her research stating that "given the large sample that Borys used in her study (2,332 participants), the same factors were used in the current study [Baer's] as subscales of the dependent variable (EAS)" (p. 62). Based on this same reasoning, it was thought that the factor analysis performed by Borys would be sufficient for use in the present study. However, when the reliability of the ES subscale (Factor I), Incidental Involvements, was found to be at .60, there was a consideration that the results of the Borys' factor analysis might be sample specific. In addition, in the present research, one item was split into three separate items which may have had an effect on the reliability and/or factor results. Therefore, a factor analysis was performed on the ES
Table 18

Means and Standard Deviations of Items on the Ethics Survey

<table>
<thead>
<tr>
<th>Survey Items</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Accepting a gift worth under $10 from your client.</td>
<td>2.75</td>
<td>1.09</td>
</tr>
<tr>
<td>2. Accepting a client’s invitation to a special occasion (e.g., his wedding or graduation).</td>
<td>2.58</td>
<td>1.03</td>
</tr>
<tr>
<td>3. Providing individual counseling/therapy to a friend of your ongoing client.</td>
<td>3.02</td>
<td>1.10</td>
</tr>
<tr>
<td>4. Selling a product to a client.</td>
<td>1.40</td>
<td>0.76</td>
</tr>
<tr>
<td>5. Becoming friends with your client after termination.</td>
<td>2.07</td>
<td>0.96</td>
</tr>
<tr>
<td>6. Accepting a gift worth over $50 from your client.</td>
<td>1.35</td>
<td>0.69</td>
</tr>
<tr>
<td>7. Providing counseling/therapy to your current employee.</td>
<td>1.39</td>
<td>0.78</td>
</tr>
<tr>
<td>8. Inviting clients to your office/clinic open house.</td>
<td>2.28</td>
<td>1.55</td>
</tr>
<tr>
<td>10. Providing counseling/therapy to a current student or supervisee.</td>
<td>1.73</td>
<td>1.02</td>
</tr>
<tr>
<td>11. Disclosing details of your personal stresses to your client.</td>
<td>1.90</td>
<td>0.89</td>
</tr>
<tr>
<td>13. Employing your client.</td>
<td>1.40</td>
<td>0.78</td>
</tr>
<tr>
<td>14. Going out to eat with your client.</td>
<td>1.93</td>
<td>0.86</td>
</tr>
<tr>
<td>15. Buying goods or services from your client.</td>
<td>1.70</td>
<td>0.88</td>
</tr>
<tr>
<td>16. Engaging in sexual activity with your client.</td>
<td>1.02</td>
<td>0.29</td>
</tr>
<tr>
<td>17. Inviting your client(s) to a personal party or social event.</td>
<td>1.37</td>
<td>0.67</td>
</tr>
<tr>
<td>18. Providing individual counseling/therapy to a relative of your ongoing client.</td>
<td>2.87</td>
<td>1.07</td>
</tr>
<tr>
<td>19. Accepting a service or product as payment for counseling/therapy.</td>
<td>2.14</td>
<td>1.11</td>
</tr>
<tr>
<td>20. Engaging in sexual activity with your client after termination of treatment.</td>
<td>1.25</td>
<td>0.68</td>
</tr>
<tr>
<td>21. Providing individual counseling/therapy to a lover of your ongoing client.</td>
<td>2.48</td>
<td>1.12</td>
</tr>
<tr>
<td>22. Allowing your client to enroll in your class for a grade.</td>
<td>1.67</td>
<td>1.07</td>
</tr>
</tbody>
</table>

n = 417.
utilizing principal components analysis to extract factors. This statistical procedure was conducted to examine the number of factors extracted and the loadings of the factors for the sample in the current study.

The analysis was performed on the SPSS/PC+ computer package (SPSS, Inc., 1992b). Table 18 contains the univariate statistics by item (means and standard deviations). As previously stated, the social bias items, 9 and 12, were excluded from this analysis. However, the "not sure" items were included in the univariate statistics which may have had a slight effect of pulling down the mean on some items that had a greater number of these responses. Although, only one item had a response of "not sure" that was greater than 2% and this was item 8, which had 13.1% of "not sure" responses (Table 19). Therefore, it is likely that the "not sure" responses had little, if any effect, on the univariate or multivariate statistics. In reviewing Tables 18 and 19, it is evident that there were more respondents endorsing the "never" or "rare" categories than the categories of "always", "most" or "some".
Table 19
Respondents' Endorsement of Each Item on the Ethics Survey by Frequency and Percent

<table>
<thead>
<tr>
<th>Item</th>
<th>N</th>
<th>Always</th>
<th>Most</th>
<th>Some</th>
<th>Rare</th>
<th>Never</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepting a gift worth under $10 from your client.</td>
<td>448</td>
<td>15</td>
<td>98</td>
<td>173</td>
<td>99</td>
<td>55</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3%</td>
<td>21.9%</td>
<td>36.6%</td>
<td>22.1%</td>
<td>12.3%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Accepting a client's invitation to a special occasion</td>
<td>447</td>
<td>9</td>
<td>73</td>
<td>154</td>
<td>151</td>
<td>53</td>
<td>7</td>
</tr>
<tr>
<td>(e.g., his/her wedding or graduation).</td>
<td></td>
<td>2.0%</td>
<td>16.3%</td>
<td>34.4%</td>
<td>33.6%</td>
<td>11.9%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Providing individual counseling/therapy to a friend of your</td>
<td>448</td>
<td>28</td>
<td>138</td>
<td>165</td>
<td>68</td>
<td>44</td>
<td>5</td>
</tr>
<tr>
<td>ongoing client.</td>
<td></td>
<td>6.2%</td>
<td>30.8%</td>
<td>36.8%</td>
<td>15.2%</td>
<td>9.8%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Selling a product to a client.</td>
<td>444</td>
<td>3</td>
<td>4</td>
<td>41</td>
<td>82</td>
<td>308</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.7%</td>
<td>0.9%</td>
<td>9.2%</td>
<td>18.5%</td>
<td>69.4%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Becoming friends with your client after termination.</td>
<td>447</td>
<td>5</td>
<td>29</td>
<td>101</td>
<td>190</td>
<td>112</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1%</td>
<td>6.5%</td>
<td>22.6%</td>
<td>42.5%</td>
<td>25.1%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Accepting a gift worth over $50 from your client.</td>
<td>446</td>
<td>3</td>
<td>4</td>
<td>21</td>
<td>103</td>
<td>308</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.7%</td>
<td>0.9%</td>
<td>4.7%</td>
<td>23.1%</td>
<td>68.9%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Providing counseling/therapy to your current employee.</td>
<td>448</td>
<td>4</td>
<td>6</td>
<td>30</td>
<td>93</td>
<td>316</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.9%</td>
<td>1.3%</td>
<td>6.7%</td>
<td>18.5%</td>
<td>70.5%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Inviting clients to your office/clinic open house.</td>
<td>444</td>
<td>36</td>
<td>85</td>
<td>67</td>
<td>64</td>
<td>113</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.1%</td>
<td>19.1%</td>
<td>19.5%</td>
<td>14.4%</td>
<td>25.4%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Accepting a handshake offered by your client.</td>
<td>446</td>
<td>262</td>
<td>172</td>
<td>10</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>58.7%</td>
<td>38.6%</td>
<td>2.2%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>
Table 19 (continued)

<table>
<thead>
<tr>
<th>Item</th>
<th>n</th>
<th>Always</th>
<th>Most</th>
<th>Some</th>
<th>Rare</th>
<th>Never</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing counseling/therapy to a current student or supervisee.</td>
<td>447</td>
<td>5</td>
<td>32</td>
<td>54</td>
<td>116</td>
<td>231</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1%</td>
<td>7.2%</td>
<td>12.1%</td>
<td>25.9%</td>
<td>51.7%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Disclosing details of your current personal stresses to your client.</td>
<td>447</td>
<td>4</td>
<td>9</td>
<td>105</td>
<td>151</td>
<td>177</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.9%</td>
<td>2.0%</td>
<td>23.5%</td>
<td>33.8%</td>
<td>39.6%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Being sexually attracted to a client.</td>
<td>429</td>
<td>53</td>
<td>23</td>
<td>26</td>
<td>13</td>
<td>250</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13.7%</td>
<td>5.4%</td>
<td>6.1%</td>
<td>3.0%</td>
<td>58.3%</td>
<td>13.5%</td>
</tr>
<tr>
<td>Employing your client.</td>
<td>446</td>
<td>7</td>
<td>6</td>
<td>23</td>
<td>93</td>
<td>309</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.6%</td>
<td>1.3%</td>
<td>5.2%</td>
<td>20.9%</td>
<td>69.3%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Going out to eat with your client.</td>
<td>449</td>
<td>3</td>
<td>10</td>
<td>98</td>
<td>178</td>
<td>157</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.7%</td>
<td>2.2%</td>
<td>21.8%</td>
<td>39.6%</td>
<td>35.0%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Buying goods or services from your client.</td>
<td>447</td>
<td>3</td>
<td>10</td>
<td>72</td>
<td>139</td>
<td>215</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.7%</td>
<td>2.2%</td>
<td>16.1%</td>
<td>31.1%</td>
<td>48.1%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Engaging in sexual activity with your current client.</td>
<td>447</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>444</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.4%</td>
<td>0.0%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>99.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Inviting your client(s) to a personal party or social event.</td>
<td>448</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>126</td>
<td>301</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.7%</td>
<td>1.1%</td>
<td>1.8%</td>
<td>29.1%</td>
<td>67.2%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Providing individual counseling/therapy to a relative of your ongoing client.</td>
<td>442</td>
<td>21</td>
<td>111</td>
<td>166</td>
<td>96</td>
<td>42</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.7%</td>
<td>25.1%</td>
<td>37.6%</td>
<td>21.7%</td>
<td>9.5%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>
Table 19 (continued)

<table>
<thead>
<tr>
<th>Item</th>
<th>n</th>
<th>Always</th>
<th>Most</th>
<th>Some</th>
<th>Rare</th>
<th>Never</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepting a service or product as payment for counseling/therapy.</td>
<td>445</td>
<td>8</td>
<td>40</td>
<td>131</td>
<td>130</td>
<td>113</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.8%</td>
<td>9.0%</td>
<td>29.4%</td>
<td>29.2%</td>
<td>25.4%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Engaging in sexual activity with your client after termination</td>
<td>444</td>
<td>3</td>
<td>2</td>
<td>16</td>
<td>87</td>
<td>318</td>
<td>18</td>
</tr>
<tr>
<td>of treatment.</td>
<td></td>
<td>0.7%</td>
<td>0.4%</td>
<td>3.6%</td>
<td>19.6%</td>
<td>71.6%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Providing individual counseling/therapy to a lover of your</td>
<td>446</td>
<td>14</td>
<td>74</td>
<td>143</td>
<td>121</td>
<td>85</td>
<td>9</td>
</tr>
<tr>
<td>ongoing client.</td>
<td></td>
<td>3.1%</td>
<td>16.6%</td>
<td>32.1%</td>
<td>27.1%</td>
<td>19.1%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Allowing your client to enroll in your class for a grade.</td>
<td>447</td>
<td>5</td>
<td>25</td>
<td>67</td>
<td>106</td>
<td>209</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1%</td>
<td>5.6%</td>
<td>15.0%</td>
<td>23.7%</td>
<td>46.8%</td>
<td>7.8%</td>
</tr>
</tbody>
</table>

*Note. Not all ratings sum to 100% due to rounding.*
The correlation matrix for the principal components analysis is reported in Table 20. Examination of the correlation matrix revealed that approximately three-fourths of the correlations between the items are small (less than .3). However, except for item 8, all items had at least a moderate correlation with at least one of the other items in the matrix.

Next, an eigenvalue and the percentage of the variance explained was computed for each factor (Table 21). This data must be examined when making a decision on the number of factors to be retained. Four factors satisfied the Kaiser’s criterion (a minimum eigenvalue of 1.0 or more) and Cattell’s scree test. The total variance accounted for by the retained factors was 52.3% and the percentage of variance explained by each factor was as follows: Factor 1, 29.6%; Factor 2, 9.1%; Factor 3, 7.9%, and; Factor 4, 5.7% (Table 21).

The unrotated loadings for the retained factors, as well as, the communality for each variable based on these factors are presented in Table 22. Twelve of the twenty items loaded on the first factor, three on the second factor, three on the third factor, and only one on fourth factor. Item 16 loaded on factors 1 and 4. The communality for items 11 and 19 are the smallest. This indicates that they have less in common with the other items in the analysis and more variance unaccounted for by the factor solution (Hair, Anderson, Tatham, & Black, 1992).
Table 20

Intercorrelations of the Items on the Ethics Survey

| Item | 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | 10  | 11  | 12  | 13  | 14  | 15  | 16  | 17  | 18  | 19  | 20  | 21  | 22  |
|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| 1    | 1.00|     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| 2    | .33 | 1.00|     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| 3    | .22 | .17 | 1.00|     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| 4    | .23 | .22 | .20 | 1.00|     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| 5    | .27 | .26 | .28 | .33 | 1.00|     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| 6    | .40 | .31 | .25 | .41 | .37 | .10 | .27 | .10 |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| 7    | .12 | .27 | .15 | .17 | .29 | .29 | .23 | .10 |     |     |     |     |     |     |     |     |     |     |     |     |     |
| 8    | .07 | .17 | .11 | .25 | .26 | .22 | .22 | .59 | .37 | .37 | .22 | .46 | .46 | .46 | .46 | .46 | .46 | .46 | .46 | .46 | .46 |
| 9    | .07 | .21 | .20 | .23 | .24 | .33 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 |
| 10   | .15 | .36 | .15 | .31 | .37 | .28 | .32 | .27 | .27 | .27 | .27 | .27 | .27 | .27 | .27 | .27 | .27 | .27 | .27 | .27 | .27 |
| 11   | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 |
| 12   | .29 | .29 | .25 | .39 | .40 | .38 | .33 | .26 | .25 | .33 | .33 | .33 | .33 | .33 | .33 | .33 | .33 | .33 | .33 | .33 | .33 |
| 13   | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 |
| 14   | .22 | .21 | .37 | .41 | .35 | .41 | .31 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 | .22 |
| 15   | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 |
| 16   | .19 | .14 | .63 | .15 | .17 | .17 | .16 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 | .15 |
| 18   | .16 | .16 | .11 | .27 | .41 | .31 | .20 | .09 | .14 | .23 | .23 | .23 | .23 | .23 | .23 | .23 | .23 | .23 | .23 | .23 | .23 |
| 19   | .08 | .20 | .47 | .13 | .17 | .19 | .16 | .14 | .13 | .21 | .20 | .20 | .16 | .22 | .17 | .22 | .22 | .22 | .22 | .22 | .22 |
| 20   | .03 | .12 | .24 | .19 | .22 | .14 | .39 | .09 | .47 | .16 | .37 | .25 | .25 | .25 | .25 | .25 | .25 | .25 | .25 | .25 | .25 |

Note. n = 417.
Table 21

*Eigenvalues and Percentage of Variance for Pre-rotated Factors*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Eigenvalue</th>
<th>Explained Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>1</td>
<td>5.91</td>
<td>29.6</td>
</tr>
<tr>
<td>2</td>
<td>1.82</td>
<td>9.1</td>
</tr>
<tr>
<td>3</td>
<td>1.58</td>
<td>7.9</td>
</tr>
<tr>
<td>4</td>
<td>1.15</td>
<td>5.7</td>
</tr>
<tr>
<td>5</td>
<td>0.96</td>
<td>4.8</td>
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<tr>
<td>6</td>
<td>0.87</td>
<td>4.3</td>
</tr>
<tr>
<td>7</td>
<td>0.84</td>
<td>4.2</td>
</tr>
<tr>
<td>8</td>
<td>0.78</td>
<td>3.9</td>
</tr>
<tr>
<td>9</td>
<td>0.76</td>
<td>3.8</td>
</tr>
<tr>
<td>10</td>
<td>0.69</td>
<td>3.4</td>
</tr>
<tr>
<td>11</td>
<td>0.65</td>
<td>3.3</td>
</tr>
<tr>
<td>12</td>
<td>0.60</td>
<td>3.0</td>
</tr>
<tr>
<td>13</td>
<td>0.54</td>
<td>2.7</td>
</tr>
<tr>
<td>14</td>
<td>0.51</td>
<td>2.6</td>
</tr>
<tr>
<td>15</td>
<td>0.47</td>
<td>2.4</td>
</tr>
<tr>
<td>16</td>
<td>0.45</td>
<td>2.2</td>
</tr>
<tr>
<td>17</td>
<td>0.44</td>
<td>2.2</td>
</tr>
<tr>
<td>18</td>
<td>0.40</td>
<td>2.0</td>
</tr>
<tr>
<td>19</td>
<td>0.34</td>
<td>1.7</td>
</tr>
<tr>
<td>20</td>
<td>0.24</td>
<td>1.2</td>
</tr>
</tbody>
</table>
Table 22

Unrotated Factor Loadings and Communality of Variables

<table>
<thead>
<tr>
<th>Items</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Communality</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.</td>
<td>.70</td>
<td>-.18</td>
<td>.01</td>
<td>-.02</td>
<td>.52</td>
</tr>
<tr>
<td>15.</td>
<td>.67</td>
<td>-.13</td>
<td>.13</td>
<td>.09</td>
<td>.49</td>
</tr>
<tr>
<td>5.</td>
<td>.65</td>
<td>-.14</td>
<td>.15</td>
<td>.11</td>
<td>.48</td>
</tr>
<tr>
<td>7.</td>
<td>.62</td>
<td>-.21</td>
<td>-.40</td>
<td>.06</td>
<td>.59</td>
</tr>
<tr>
<td>6.</td>
<td>.60</td>
<td>-.10</td>
<td>.33</td>
<td>-.24</td>
<td>.54</td>
</tr>
<tr>
<td>14.</td>
<td>.59</td>
<td>-.23</td>
<td>-.00</td>
<td>.28</td>
<td>.48</td>
</tr>
<tr>
<td>4.</td>
<td>.58</td>
<td>-.18</td>
<td>.11</td>
<td>-.26</td>
<td>.45</td>
</tr>
<tr>
<td>13.</td>
<td>.57</td>
<td>-.06</td>
<td>-.34</td>
<td>.01</td>
<td>.44</td>
</tr>
<tr>
<td>11.</td>
<td>.52</td>
<td>-.00</td>
<td>.09</td>
<td>-.08</td>
<td>.28</td>
</tr>
<tr>
<td>2.</td>
<td>.51</td>
<td>-.10</td>
<td>.29</td>
<td>.41</td>
<td>.53</td>
</tr>
<tr>
<td>19.</td>
<td>.51</td>
<td>.08</td>
<td>.16</td>
<td>.16</td>
<td>.32</td>
</tr>
<tr>
<td>20.</td>
<td>.50</td>
<td>-.14</td>
<td>.08</td>
<td>-.45</td>
<td>.48</td>
</tr>
<tr>
<td>18.</td>
<td>.47</td>
<td>.78</td>
<td>-.03</td>
<td>-.05</td>
<td>.83</td>
</tr>
<tr>
<td>21.</td>
<td>.46</td>
<td>.70</td>
<td>-.05</td>
<td>.03</td>
<td>.71</td>
</tr>
<tr>
<td>3.</td>
<td>.48</td>
<td>.63</td>
<td>.08</td>
<td>-.01</td>
<td>.63</td>
</tr>
<tr>
<td>10.</td>
<td>.51</td>
<td>-.16</td>
<td>-.57</td>
<td>.09</td>
<td>.62</td>
</tr>
<tr>
<td>22.</td>
<td>.50</td>
<td>.12</td>
<td>-.57</td>
<td>-.03</td>
<td>.59</td>
</tr>
<tr>
<td>1.</td>
<td>.38</td>
<td>.01</td>
<td>.59</td>
<td>-.05</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>.41</td>
<td>-.09</td>
<td>.10</td>
<td>.50</td>
<td>.44</td>
</tr>
<tr>
<td>16.</td>
<td>.50</td>
<td>-.16</td>
<td>-.05</td>
<td>-.50</td>
<td>.53</td>
</tr>
</tbody>
</table>

An orthogonal rotation was chosen to provide a more conceptually meaningful factor pattern so that a set of underlying constructs could be identified which account for as much of the variance on the ES as possible. Therefore, a Varimax rotation was utilized to minimize the number of items that have a high loading on one factor, such as on factor 1 (Dunteman, 1989)(Table 23).
Table 23

**Varimax Rotated Component Analysis Factor Loadings**

<table>
<thead>
<tr>
<th>Items</th>
<th>Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>16.</td>
<td>.68</td>
</tr>
<tr>
<td>20.</td>
<td>.67</td>
</tr>
<tr>
<td>6.</td>
<td>.64</td>
</tr>
<tr>
<td>4.</td>
<td>.60</td>
</tr>
<tr>
<td>17.</td>
<td>.47</td>
</tr>
<tr>
<td>1.</td>
<td>.43</td>
</tr>
<tr>
<td>11.</td>
<td>.39</td>
</tr>
<tr>
<td>2.</td>
<td>.12</td>
</tr>
<tr>
<td>8.</td>
<td>-.06</td>
</tr>
<tr>
<td>14.</td>
<td>.20</td>
</tr>
<tr>
<td>5.</td>
<td>.38</td>
</tr>
<tr>
<td>15.</td>
<td>.40</td>
</tr>
<tr>
<td>19.</td>
<td>.21</td>
</tr>
<tr>
<td>10.</td>
<td>.11</td>
</tr>
<tr>
<td>22.</td>
<td>.12</td>
</tr>
<tr>
<td>7.</td>
<td>.26</td>
</tr>
<tr>
<td>13.</td>
<td>.24</td>
</tr>
<tr>
<td>18.</td>
<td>.10</td>
</tr>
<tr>
<td>21.</td>
<td>.05</td>
</tr>
<tr>
<td>3.</td>
<td>.15</td>
</tr>
</tbody>
</table>

The result from the Varimax rotation was a distribution of the items and a more simple solution which was utilized to interpret the underlying constructs.

The four-factor solution in the present study was different from Borys' (1988).

Table 24 compares the factor indices and loadings of this analysis with those of Borys' (original indices).
Table 24

Comparison of Factor Indices and Loadings of Present Study with Original Indices and Loadings for the Ethics Survey

<table>
<thead>
<tr>
<th>Items</th>
<th>Present Factor Analysis</th>
<th>Original Factor Analysis*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Factor</td>
<td>Loading</td>
</tr>
<tr>
<td>Accepting a gift worth under $10 from your client.</td>
<td>I</td>
<td>.43</td>
</tr>
<tr>
<td>Selling a product to a client.</td>
<td>I</td>
<td>.60</td>
</tr>
<tr>
<td>Accepting a gift worth over $50 from your client.</td>
<td>I</td>
<td>.64</td>
</tr>
<tr>
<td>Disclosing details of your current personal stresses to your client.</td>
<td>I</td>
<td>.39</td>
</tr>
<tr>
<td>Being sexually attracted to a client.</td>
<td>b</td>
<td>b</td>
</tr>
<tr>
<td>Engaging in sexual activity with your current client.</td>
<td>I</td>
<td>.68</td>
</tr>
<tr>
<td>Inviting your client(s) to a personal party or social event.</td>
<td>I</td>
<td>.47</td>
</tr>
<tr>
<td>Engaging in sexual activity with your client after termination of treatment</td>
<td>I</td>
<td>.67</td>
</tr>
<tr>
<td>Accepting a client's invitation to a special occasion (e.g., his/her wedding or graduation).</td>
<td>II</td>
<td>.71</td>
</tr>
<tr>
<td>Becoming friends with your client after termination.</td>
<td>II</td>
<td>.54</td>
</tr>
<tr>
<td>Inviting clients to your office/clinic open house.</td>
<td>II</td>
<td>.64</td>
</tr>
<tr>
<td>Accepting a handshake offered by your client.</td>
<td>b</td>
<td>b</td>
</tr>
</tbody>
</table>
Table 24 (continued)

Comparison of Factor Indices and Loadings of Present Study with Original Indices and Loadings for the Ethics Survey

<table>
<thead>
<tr>
<th>Items</th>
<th>Present Factor Analysis</th>
<th>Original Factor Analysis*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Factor</td>
<td>Loading</td>
</tr>
<tr>
<td>Going out to eat with your client.</td>
<td>II</td>
<td>.58</td>
</tr>
<tr>
<td>Buying goods or services from your client.</td>
<td>II</td>
<td>.52</td>
</tr>
<tr>
<td>Accepting a service or product as payment for counseling/therapy.</td>
<td>II</td>
<td>.45</td>
</tr>
<tr>
<td>Providing counseling/therapy to your current employee.</td>
<td>III</td>
<td>.67</td>
</tr>
<tr>
<td>Providing counseling/therapy to a current student or supervisee.</td>
<td>III</td>
<td>.76</td>
</tr>
<tr>
<td>Employing your client.</td>
<td>III</td>
<td>.56</td>
</tr>
<tr>
<td>Allowing your client to enroll in your class for a grade.</td>
<td>III</td>
<td>.70</td>
</tr>
<tr>
<td>Providing individual counseling/therapy to a friend of your ongoing client.</td>
<td>IV</td>
<td>.76</td>
</tr>
<tr>
<td>Providing individual counseling/therapy to a relative of your ongoing client.</td>
<td>IV</td>
<td>.89</td>
</tr>
<tr>
<td>Providing individual counseling/therapy to a lover of your ongoing client.</td>
<td>IV</td>
<td>.82</td>
</tr>
</tbody>
</table>

*The data from the original factor analysis were reported in "Dual Relationships Between Therapist and Client: A National Survey of Clinicians' Attitudes and Practices" by D. S. Borys, 1988, Doctoral dissertation, University of California, Los Angeles, p. 67, 68. *These items were omitted in the Borys' (original) factor analysis and the factor analysis for the present study. *This item was not included in the original factor analysis. *These three items were combined into one item in Borys' study with a loading of .51 on Factor III.
Stevens (1992) recommends that only loadings .40 or greater be interpreted (p. 384). There was only one loading which was less than .40, however, since the sample size was greater than 400 and the loading was .39, it seemed appropriate to include this item on the factor, statistically and practically (Stevens, 1992, p. 383-384). All items in this factor solution had loadings from .39 to .89. Given that subsequent analyses in the present study utilize these factors (i.e., underlying constructs of the survey items) and to facilitate the understanding of each factor in the descriptive text below, the renamed factor indices and a list of items loading on each are reported in Table 25.

Factor I accounted for 29.6% of the total variance and 56.5% of the common variance. It was composed of behaviors that reflect monetary, personal, and sexual issues. The items regarding client gift giving contain an underlying element of closeness and caring for the counselor/therapist. The remaining items in factor I also have underpinnings in a personal, intimate relationship. Therefore, this factor was labelled "Intimate Involvements".

The second factor (II) includes items that have extra-therapeutic involvements. Some are incidental, one-time occasions, as described by Borys (1988), and others are possibly more long-term and social in nature. Even though two items (15 and 19) which load on this factor involve monetary issues, they appear to be different than those on factor I. These items place the counselor/therapist in different roles which push boundaries into a more social realm. This factor was labelled "Social Involvements". Factor II accounted for 9.1% of the total variance and 17.4% of the common variance.
### Table 25

**Factor Indices and Composite Items for the Ethics Survey**

<table>
<thead>
<tr>
<th>Factor Indices</th>
<th>Item No.</th>
<th>Composite Items</th>
</tr>
</thead>
</table>

#### I. Intimate Involvements

1. Accepting a gift worth under $10 from your client.
4. Selling a product to a client.
6. Accepting a gift worth over $50 from your client.
11. Disclosing details of your personal stresses to your client.
17. Inviting your client(s) to a personal party or social event.

#### II. Social Involvements

2. Accepting a client's invitation to a special occasion (e.g., his wedding or graduation).
5. Becoming friends with your client after termination.
8. Inviting clients to your office/clinic open house.
14. Going out to eat with your client.
15. Buying goods or services from your client.
19. Accepting a service or product as payment for counseling/therapy.
Table 25 (continued)

Factor Indices and Composite Items for the Ethics Survey

<table>
<thead>
<tr>
<th>Factor Indices</th>
<th>Item No.</th>
<th>Composite Items</th>
</tr>
</thead>
</table>

III. Dual Professional Roles

7. Providing counseling/therapy to your current employee.
10. Providing counseling/therapy to a current student or supervisee.
22. Allowing your client to enroll in your class for a grade.

IV. Professional Objectivity

3. Providing individual counseling/therapy to a friend of your ongoing client.
18. Providing individual counseling/therapy to a relative of your ongoing client.
21. Providing individual counseling/therapy to a lover of your ongoing client.
The next factor, factor III, was the underlying construct for behaviors that placed a counselor in what are typically thought of as dual roles, though not all of them are necessarily unethical according to the ACA codes. This factor was labelled "Dual Professional Roles". Factor III accounted for 7.9% of the total variance and 15.1% of the common variance.

Factor IV, the last factor, accounted for 5.7% of the total variance and 11% of the common variance. This factor, labelled "Professional Objectivity", consisted of referral and client load issues surrounding counseling a friend, relative, or lover of a client. Objectivity and confidentiality are very difficult to maintain and control when a counselor/therapist is counseling significant others of a client.

In summary, a four-factor solution was extracted through the use of principal components analysis. The analysis was utilized to identify a subset of constructs for the items in the ES (A and B). Total variance accounted for by the factors was 52.3%. Given that these factors are based on original data, not derived scores, the correlations between factors will not remain zero because of the equal weights given to each item (Table 26). The factors were labelled: Intimate Involvements, Social Involvements, Dual Professional Roles, and Professional Objectivity.
Table 26

**Correlation Matrix of Retained Factors**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>.62**</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>.41**</td>
<td>.46**</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>.34**</td>
<td>.33**</td>
<td>.30**</td>
<td>1.00</td>
</tr>
</tbody>
</table>

\(n = 417\).

**\(p < .001\)**

**Reliability of the ES (A and B) Based upon the New Factor Solution**

Utilizing the new four-factor solution described above, the Cronbach alpha coefficient for the ES raised slightly to .87. The alpha coefficients for each subscale were as follows: Intimate Involvements (Factor I), .71; Social Involvements (Factor II), .79; Dual Professional Roles (Factor III), .75, and; Professional Objectivity (Factor IV), .83. Entering the data based upon the new factor solution did increase the reliability not only for the entire instrument, but also, for each factor.

**Research Questions Based Upon the New Factor Solution**

The stated research questions in Chapter One were then modified to reflect the four-factor solution of the principal components analysis. The
changes consisted of: 1) new names for the dependent variable in questions two, three, and four to represent the underlying dimensions of each particular factor, and; 2) the addition of research question five, to allow a separate analysis of the fourth dependent variable (factor 4 on the ES). Therefore, the last four research questions still investigate the relationship of the independent variables to each of the ethicality subscores (ES factors). The findings are reported by the revised research questions.

**Research Question 1**

Are the overall ethical behaviors endorsed by counselors dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender factors?

A canonical correlation analysis was conducted to investigate the relationship between the dependent variable set and the independent variable set. This analysis provided a means to study the "number and nature of independent relationships" (Stevens, 1992, p. 431) between the criterion variable set to the predictor variable set without inflating the Type I error rate by utilizing several separate univariate analyses. In this study the criterion variable set consisted of four variables measuring dual relationship behaviors: Intimate Involvements, Social Involvements, Dual Professional Roles, and Professional Objectivity. The predictor variable set consisted of 10 variables measuring therapeutic stress, personal boundaries, ambiguity, and gender: Therapeutic Relationships, Scheduling Difficulties, Professional Doubt, Work Overinvolvement, Personal Depletion, Boundary, Fusion, Tolerance for
Table 27

Means, Standard Deviations, and Scale Range for Each Variable in the
Canonical Correlation Analysis

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Scale Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dual Relationship Behaviors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intimate Involvements</td>
<td>11.27</td>
<td>3.21</td>
<td>7 - 35</td>
</tr>
<tr>
<td>Social Involvements</td>
<td>13.47</td>
<td>4.06</td>
<td>6 - 30</td>
</tr>
<tr>
<td>Dual Professional Roles</td>
<td>6.36</td>
<td>2.75</td>
<td>4 - 20</td>
</tr>
<tr>
<td>Professional Objectivity</td>
<td>8.61</td>
<td>2.74</td>
<td>3 - 15</td>
</tr>
<tr>
<td><strong>Therapeutic Stress</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic Relationships</td>
<td>34.59</td>
<td>11.89</td>
<td>13 - 70</td>
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<tr>
<td>Scheduling Difficulties</td>
<td>11.70</td>
<td>4.90</td>
<td>4 - 26</td>
</tr>
<tr>
<td>Professional Doubt</td>
<td>11.13</td>
<td>4.39</td>
<td>4 - 25</td>
</tr>
<tr>
<td>Work Overinvolvement</td>
<td>13.29</td>
<td>4.90</td>
<td>5 - 28</td>
</tr>
<tr>
<td>Personal Depletion</td>
<td>10.80</td>
<td>4.19</td>
<td>3 - 21</td>
</tr>
<tr>
<td><strong>Personal Boundary Preference</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boundary</td>
<td>68.33</td>
<td>10.40</td>
<td>27 - 96</td>
</tr>
<tr>
<td>Fusion</td>
<td>53.88</td>
<td>10.91</td>
<td>23 - 87</td>
</tr>
<tr>
<td><strong>Tolerance for Ambiguity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolerance</td>
<td>12.75</td>
<td>3.02</td>
<td>0 - 19</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client</td>
<td>.53</td>
<td>.50</td>
<td>0 - 1</td>
</tr>
<tr>
<td>Counselor/Therapist</td>
<td>.48</td>
<td>.50</td>
<td>0 - 1</td>
</tr>
</tbody>
</table>

Note. n = 273. Dual Relationship Behaviors from the Ethics Scale A and B, Therapeutic Stresses from the Therapeutic Stresses Rating Scale, Personal Boundary Preference from the Personal Boundary Questionnaire, Tolerance for Ambiguity from the AT-20 Scale, and Gender of Client and Counselor/Therapist from the Demographic Information Questionnaire.

Gender: Gender of Client and Counselor/Therapist were both coded as follows: 0 = Female; 1 = Male.
Ambiguity, Gender of Client, and Gender of Counselor/Therapist. Table 27 contains the descriptive statistics for each variable utilized in this analysis.

Prior to the analysis, the assumptions for canonical correlation were examined. One assumption that appeared attenuated required the measurement error of the variables to be minimal. The reliabilities of the AT-20 (.67) and the Boundary factor (.68) were slightly lower than expected which may tend to weaken the correlation matrix coefficients (Thompson, 1984). However, the other assumptions appeared to be within acceptable margins given this analysis is robust with regard to the violation of the multivariate normal distribution assumption (Stevens, 1992).

By examining the correlation matrix, it is evident that the association between the dependent and independent sets of variables appears weak, especially, given that approximately 90% of these simple correlations are less than .20 (Table 28). However, there are two independent variables which had a low but significant negative correlation with the Dual Professional Roles variable: the Tolerance for Ambiguity variable (-.18) and the Counselor/Therapist (Gender) variable (-.19).

The correlations between the dependent variables (refer to variables 1 to 4 in Table 28) were low to moderate and the correlations between the independent variables were weak considering that over half of the simple correlations were .30 or less. Within the independent variable set, the associations between the Therapeutic Stress variables were moderate to moderately high, although not consistently high enough for multicollinearity to become a problem. The Therapeutic Stress factors also had a low correlation
Table 28

Intercorrelations of Dual Relationship Behaviors, Therapeutic Stress, Personal Boundary Preference, Tolerance for Ambiguity, and Gender

<table>
<thead>
<tr>
<th>Variable</th>
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<td>4. Professional Objectivity</td>
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<td>11. Fusion</td>
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<td>.01</td>
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<td>.45**</td>
<td>.22**</td>
<td>.37**</td>
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<td>-.02</td>
<td>-.18*</td>
<td>-.15</td>
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<td>-.07</td>
<td>-.04</td>
<td>-.08</td>
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<td>-.19*</td>
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<td>.16*</td>
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Note. Dual Relationship Behaviors from the Ethics Scale A and B, Therapeutic Stresses from the Therapeutic Stresses Rating Scale, Personal Boundary Preference from the Personal Boundary Questionnaire, Tolerance for Ambiguity from the Ambiguity-20 Scale, and Gender of Client and Counselor/Therapist from the Demographic Information Questionnaire. *Gender of Client and Counselor/Therapist were both coded as follows: 0=female; 1=male.
*2 < .01, two-tailed  **2 < .001, two-tailed.
with the Boundary and Fusion variables. In addition, Tolerance for Ambiguity had low but significant negative correlations with Professional Doubt, Boundary, and Fusion.

It was possible to calculate four canonical functions in this analysis. Hair et al. (1992) recommended "three criteria be used in conjunction with each other to decide which canonical functions should be interpreted" (p. 200). One criteria utilized in this study was the level of statistical significance of the functions. The first statistical hypothesis stated that all squared canonical correlation coefficients are equal to zero. Function 1 was statistically significant at an alpha of .05, Wilkes’ Lambda = .73, $F (40, 983.95) = 2.10, p < .0001$. The second hypothesis tested stated that the squared canonical correlation coefficients for the second, third and fourth functions are equal to zero. This hypothesis was rejected, therefore, function 2 was also statistically significant, Wilkes’ Lambda = .85, $F (27, 759.98) = 1.62, p < .025$. Both functions 3 and 4 were not found to be statistically significant. It is important to note that the significance for the first and second functions could be due solely to the large sample size utilized, therefore, it was necessary to consider other criteria.

The second criteria examined the magnitude of the squared canonical correlations ($R_c^2$) which estimates the amount of variance shared by the two canonical variates. This should be at least .10 or greater for the interpretation to be meaningful. Only function 1 met this criteria; $R_{c(1)}^2 = .137$ (Table 29).
### Table 29

**Summary of Canonical Correlation Analysis**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Canonical Variate 1</th>
<th></th>
<th>Canonical Variate 2</th>
<th></th>
</tr>
</thead>
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<tr>
<td></td>
<td>b</td>
<td>s</td>
<td>b</td>
<td>s</td>
</tr>
<tr>
<td><strong>Independent Variable Set</strong></td>
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<td></td>
</tr>
<tr>
<td>Therapeutic Relationships</td>
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<td>.029</td>
<td>.251</td>
<td>.305</td>
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<tr>
<td>Scheduling Difficulties</td>
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<td>-.027</td>
<td>.246</td>
<td>.081</td>
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<tr>
<td>Professional Doubt</td>
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<td>-.056</td>
<td>.445</td>
<td>.368</td>
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<tr>
<td>Work Overinvolvement</td>
<td>-.047</td>
<td>.072</td>
<td>-.189</td>
<td>-.006</td>
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<td>Personal Depletion</td>
<td>.307</td>
<td>.249</td>
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<td>Boundary</td>
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<td>-.771</td>
<td>.360</td>
<td>.208</td>
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<td>Fusion</td>
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<td>.232</td>
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<td>Tolerance for Ambiguity</td>
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<td>.193</td>
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<td>Gender of Client</td>
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<td>.296</td>
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<td>Gender of Counselor/Therapist</td>
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<td>.667</td>
<td>.705</td>
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</tr>
<tr>
<td>$R_{c(1)}^2 = .137$</td>
<td></td>
<td></td>
<td>$R_{c(2)}^2 = .089$</td>
<td></td>
</tr>
<tr>
<td>$R_{c(3)}^2 = .049$</td>
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<td>$R_{c(4)}^2 = .020$</td>
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</table>

**Dependent Variable Set**

<table>
<thead>
<tr>
<th>Variables</th>
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</thead>
<tbody>
<tr>
<td>Intimate Involvements</td>
<td>.310</td>
<td>.205</td>
<td>-.726</td>
<td>-.798</td>
</tr>
<tr>
<td>Social Involvements</td>
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<td>.302</td>
<td>.336</td>
<td>-.398</td>
</tr>
<tr>
<td>Dual Professional Roles</td>
<td>-1.186</td>
<td>-.612</td>
<td>-.138</td>
<td>-.563</td>
</tr>
<tr>
<td>Professional Objectivity</td>
<td>.199</td>
<td>.062</td>
<td>-.596</td>
<td>-.799</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>PV</th>
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<tbody>
<tr>
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<td>.437</td>
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<tr>
<td>Rd</td>
<td>.017</td>
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<td>.039</td>
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<tr>
<td>Rd</td>
<td>.070</td>
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</tbody>
</table>

**Note.** b = standardized canonical coefficients (weights); s = structure coefficients; PV = proportion of variance explained; Rd = redundancy; Rd = Total Redundancy.
The last criteria required the calculation of the Stewart-Love index of redundancy and the examination of total redundancy (Thompson, 1984). Total redundancy indicated that seven percent of the total variance in the dependent variable set could be predicted or explained by the relationship between the dependent variable set and the independent variable set. In other words, this was how much variance in the dependent variable set that would be accounted for if all four functions were interpreted. The redundancy index indicated that 1.7% of the variance in the dependent variable set could be explained by the first canonical function and an additional 3.9% for the second canonical function. Thus, 5.6% of the total variance in the dependent variable set can be explained by the first two canonical functions.

In summary, even though only the first function met all three criteria, function two met two of the criteria; the level of significance and index of redundancy. Examination of this information led to the decision to interpret canonical function 1 and 2. The number of subjects utilized in this analysis was 273 which was within the 20:1 ratio necessary to interpret the first canonical correlation with confidence. However according to Stevens (1992), caution should be exercised in the interpretation of the second canonical correlation (p. 420).

The standardized canonical coefficients (weights) which indicate the relative importance of the variables in canonical variate 1 and canonical variate 2 are reported in Table 29. Within the dependent variable set, Dual Professional Roles and Social Involvements were most important in canonical variate 1. Dual Professional Roles was weighted negatively and Social Involvements was
weighted positively. In canonical variate 2, Intimate Involvements and Professional Objectivity made the most contribution; both were weighted negatively.

Within the independent variable set, Boundary was the most relatively important variable in canonical variate 1 and was weighted negatively. Gender of Counselor/Therapist, Tolerance for Ambiguity, and Personal Depletion also contributed slightly (all positively weighted) to canonical variate 1. Gender of Counselor/Therapist was relatively more important than Professional Doubt in canonical variate 2 and both were positive. Tolerance for Ambiguity, weighted positively, and Personal Depletion, weighted negatively, also, slightly contributed to canonical variate 2.

Canonical structure coefficients, correlations between the original variables and the canonical variate scores, were utilized to interpret the meaning of each function. Meaningful correlations were interpreted as .30 or greater (Hair et al., 1992). The criterion side of the first canonical function was characterized by a moderate negative loading of Dual Professional Roles and a moderate positive loading of Social Involvements (refer to Table 29).
The second canonical function carried information on all of the dependent variables and they were weighted negatively. Intimate Involvements and Professional Objectivity (high loadings) were relatively more important than Dual Professional Roles, and Social Involvements (moderate loadings).

The predictor side of the first canonical function was characterized by a strong negative loading on Boundary, a moderate positive loading on Tolerance for Ambiguity, and a slightly lower positive loading on Gender of
Counselor/Therapist. Canonical function 2 was characterized by a high positive loading on Gender of Counselor/Therapist and a moderate positive loading on Professional Doubt and Therapeutic Relationships. Even though Therapeutic Relationships was not heavily weighted, it was interpreted given that structure coefficients are usually more stable than standardized canonical coefficients (Thompson, 1984, p. 23).

These findings suggest that female counselors who report having low boundary preference and a tolerance for ambiguity tend to endorse less dual professional roles as being ethical. They also tend to endorse more social involvements as being ethical. The findings also suggest that female counselors/therapists who tend to report stress from professional doubt and stress in maintaining therapeutic relationships in their practice endorse less dual relationship behaviors overall. In particular, they tend to strongly consider intimate involvements and professional objectivity involvements to be unethical. Conversely, those who endorse less social involvements with clients and more dual professional roles, are more likely to be male counselors who score lower on tolerance of ambiguity and higher on boundary preference.

**Research Question 2**

Are the intimate involvement behaviors endorsed by counselors dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender factors?

A multiple regression analysis was utilized to investigate the relationship between the endorsement of intimate involvements by counselors and
therapeutic stress, personal boundary preference, tolerance for ambiguity, and
gender. The multiple coefficient of correlation ($R$) was .24 which indicated a
weak relationship between the dependent variable and a linear combination of
the independent variables. Only 6 percent of the variance in the endorsement
of intimate involvements was accounted for by the linear combination of the
predictor variables. However, the model was statistically significant when all the
variables were entered into the equation simultaneously ($R^2 = .06, F (10, 354) =
2.12, p < .02$). The two variables which contributed significantly to the
endorsement of intimate involvements were gender of counselor/therapist and
boundary preference (Table 30). More specifically, holding all other
independent variables constant, males tended to endorse more intimate
involvements as ethical. Also, counselors who maintained less distance
between self and others tended to endorse more intimate involvements.

An examination of residuals was performed. All assumptions appeared
to have been met with the exception of a normal probability distribution. There
was a slight deviation of the observed residuals from the expected residuals,
however, regression analysis is robust with this assumption violation, especially
with large sample sizes (Berry & Feldman, 1985, p. 11). Out of 365 cases in
this analysis, two outliers were detected.
Table 30

Regression of Intimate involvements on Therapeutic Stress, Tolerance for Ambiguity, Boundary Preference, and Gender (Simultaneous)

<table>
<thead>
<tr>
<th>Predictor Variables</th>
<th>R²</th>
<th>Adj. R</th>
<th>b</th>
<th>t</th>
<th>p</th>
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<td>Gender of Client</td>
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<td>Fusion</td>
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<td>Gender of Counselor/Therapist</td>
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<td>-2.36</td>
<td>.02*</td>
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<tr>
<td>Scheduling Difficulties</td>
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<tr>
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<td>-1.92</td>
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<tr>
<td>Work Overinvolvement</td>
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<td>Personal Depletion</td>
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</table>

Note. n = 365. Standard error = 3.16. For Model: F = 2.12, p<.02. *p < .05.

Research Question 3

Are the social involvement behaviors endorsed by counselors dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender factors?

A multiple regression analysis was performed with the predictor variables entering the equation simultaneously. In this approach, the predictor variables did not account for a significant proportion of the variance in the criterion
variable \( R^2 = .05, F (10, 315) = 1.54, p < .12 \). In other words, the model was not statistically significant at the alpha level of .05 and, therefore, was not interpreted.

**Research Question 4**

Are the dual professional role behaviors endorsed by counselors dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender factors?

The Dual Professional Roles subscale was regressed on all the predictor variables to investigate their relationship. Findings from the simultaneous multiple regression indicated a weak relationship \( (R = .28) \) between the dependent variable and the linear combination of the independent variables. With all the independent variables in the equation, a small amount of the variance in the dependent variable \( (R^2 = .08) \) was accounted for by the linear combination of the independent variables. The model was significant \( (F (10, 356) = 2.95, p < .001) \) (Table 31).
Table 31

Regression of Dual Professional Roles on Therapeutic Stress, Tolerance for Ambiguity, Boundary Preference, and Gender (Simultaneous)

<table>
<thead>
<tr>
<th>Predictor Variables</th>
<th>$R^2$</th>
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<th>p</th>
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<td>.03</td>
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<td>.03*</td>
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<td>.78</td>
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<td>.53</td>
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<tr>
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<td></td>
<td>.18</td>
</tr>
<tr>
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<td>-.79</td>
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<td></td>
<td>.43</td>
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<tr>
<td>Work Overinvolvement</td>
<td>-.01</td>
<td>-.18</td>
<td></td>
<td></td>
<td>.86</td>
</tr>
<tr>
<td>Personal Depletion</td>
<td>.00</td>
<td>.05</td>
<td></td>
<td></td>
<td>.96</td>
</tr>
<tr>
<td>Gender of Counselor/Therapist</td>
<td>-1.16</td>
<td>-3.99</td>
<td></td>
<td></td>
<td>.01*</td>
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<tr>
<td>Tolerance for Ambiguity</td>
<td>-.08</td>
<td>-1.5</td>
<td></td>
<td></td>
<td>.13</td>
</tr>
</tbody>
</table>

Note. $n = 367$. Standard error = 2.71. For Model: $F = 2.95$, $p < .001$.

Two variables contributed significantly to the regression, holding all other independent variables constant; Fusion and Gender of Counselor/Therapist. As the endorsements of dual professional roles increase, the more likely it will be that the counselor is a male. Also, counselors who tend to endorse more dual professional roles as being ethical are more likely to blur boundaries.
The residuals for this regression were examined. Again, the assumptions appear to have been met except for a deviation in the normal probability plot of the standardized residuals.

**Research Question 5**

Are the professional objectivity behaviors endorsed by counselors dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender factors?

Another multiple regression was performed to investigate the relationship of the dependent variable to the independent variables. The multiple R value, .23, indicates a weak relationship between Professional Objectivity and the linear combination of the independent variables. Only five percent of the variance in the dependent variable could be accounted for by the independent variables. The regression model was significant ($R^2 = .05, F (10, 382), = 2.12, p < .02$) (Table 32). The most important variables contributing to the equation, holding all other independent variables constant were Fusion and Gender of Counselor/Therapist. The more endorsements of Professional Objectivity involvements, the more likely they will be made by male counselors/therapists. Also, a slight increase in fusion scores are associated with higher professional objectivity endorsements. The regression assumptions were examined as were the residuals. All assumptions appear to have been met in this analysis.
Table 32

*Regression of Professional Objectivity on Therapeutic Stress, Tolerance for Ambiguity, Boundary Preference, and Gender (Simultaneous)*

<table>
<thead>
<tr>
<th>Predictor Variables</th>
<th>$R^2$</th>
<th>Adj. R</th>
<th>$b$</th>
<th>$t$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fusion</td>
<td>.05</td>
<td>.03</td>
<td>-.03</td>
<td>-2.02</td>
<td>.04*</td>
</tr>
<tr>
<td>Gender of Client</td>
<td>-.18</td>
<td>-.65</td>
<td></td>
<td></td>
<td>.52</td>
</tr>
<tr>
<td>Boundary</td>
<td>-.02</td>
<td>-1.42</td>
<td></td>
<td></td>
<td>.16</td>
</tr>
<tr>
<td>Therapeutic Relationships</td>
<td>-.00</td>
<td>-.12</td>
<td></td>
<td></td>
<td>.90</td>
</tr>
<tr>
<td>Scheduling Difficulties</td>
<td>-.05</td>
<td>-1.33</td>
<td></td>
<td></td>
<td>.18</td>
</tr>
<tr>
<td>Professional Doubt</td>
<td>-.04</td>
<td>-.71</td>
<td></td>
<td></td>
<td>.48</td>
</tr>
<tr>
<td>Work Overinvolvement</td>
<td>-.01</td>
<td>-.18</td>
<td></td>
<td></td>
<td>.86</td>
</tr>
<tr>
<td>Personal Depetition</td>
<td>.05</td>
<td>1.03</td>
<td></td>
<td></td>
<td>.30</td>
</tr>
<tr>
<td>Gender of Counselor/Therapist</td>
<td>.74</td>
<td>-2.62</td>
<td></td>
<td></td>
<td>.01*</td>
</tr>
<tr>
<td>Tolerance for Ambiguity</td>
<td>-.04</td>
<td>-.87</td>
<td></td>
<td></td>
<td>.38</td>
</tr>
</tbody>
</table>

Note. $n = 393$. Standard error = 2.72. For Model: $F = 2.12$, $p < .02$. $^*p < .05$. 

CHAPTER V
SUMMARY, CONCLUSIONS, IMPLICATIONS,
AND RECOMMENDATIONS

This final chapter provides an ecumenical portrait of the study. It is divided into three sections. The first section provides a summary of the study. The second section suggests implications derived from the findings. Last, recommendations for research based upon the findings of this study are presented.

Summary

The purpose of this study was to investigate the relationship of dual role behaviors to selected counselor characteristics. Dual relationships occur when a counselor or therapist becomes involved in more than one role or relationship with a client, supervisee, or student. These roles may be simultaneous or sequential and sexual or nonsexual in nature. It is the expectations, obligations, and privileges inherent in the role of a professional counselor which establishes a potential for conflict when other relationships are initiated and/or maintained (Kitchener & Harding, 1990). In addition, objectivity in the therapeutic relationship may be relinquished which in turn could diminish the effectiveness of the counseling/therapy process and also result in potential harm for clients.
The ethical codes for most, if not all, human service organizations emphatically forbid sexual relations between the professional and a current client. However, there is some controversy as to whether this restriction should continue after the termination of counseling. Several research studies have been conducted to investigate therapist and client characteristics related to sexual dual relationships. These findings have been synthesized to identify the 10 most common aspects of these relationships (Pope, 1988).

Conversely, nonsexual dual relationships have only recently been explored in the literature and typically ethical codes are silent about these issues. What makes nonsexual dual relationships different from sexual ones is that they can not always be avoided, even with the best of intentions, and are not always harmful (Corey, Corey, & Callanan, 1993). However, these dual role situations frequently present a precarious balance of boundaries and also maintain a potential for harm. Reports of nonsexual dual relationship violations to counseling and psychology ethics committees have also been increasing over the last few years (American Counseling Association (ACA) Ethics Committee, 1992; American Psychological Association (APA) Ethics Committee, 1993). Therefore, it has become salient to investigate variables related to counselor attitudes toward the ethicality of dual relationship behaviors, in particular, to the nonsexual dual relationship behaviors.

The present study was designed to respond to a request in the literature for research that would investigate the contribution of counselor/therapist personality variables to the endorsement of dual role behaviors (Borys, 1988). Specifically, the present research was designed to investigate the contribution of
therapeutic stress, personal boundary tendencies, tolerance for ambiguity, and
gender of counselor and client to the endorsement of dual role behaviors.

A review of published literature failed to locate research which had
previously investigated therapeutic stress or tolerance for ambiguity in relation
to ethical behavior. Therapeutic stress was defined as stress occupationally
related to being a professional counselor/therapist. It was expected that
occupational stressors would contribute to more endorsements of dual role
behaviors. Tolerance for ambiguity was defined as an openness to other
alternatives or interpretations (English & English, 1958). Baer (1991) suggested
in her research on dual relationships that ambiguity may be a possible
moderating variable for stress. Frone (1990) in a meta-analysis study did find
that intolerance for ambiguity was a moderator for stress. Therefore, tolerance
for ambiguity was included in the present research.

In addition, personal boundary preference was included as a variable in
this research. This variable has two dimensions: boundary, which is the
distance between self and others, and fusion, which is the tendency to merge
with others. It was speculated that counselors who tended to endorse more
behaviors as being ethical would probably be more likely to score higher on the
fusion subscale or lower on the boundary subscale.

The last variable investigated in this study was gender. In previous
literature male therapists endorsed more behaviors as being ethical than did
female therapists. Borys (1988) found that female and male therapists
endorsed more ethical behaviors for their female clients than for male clients. In
her multivariate analysis, Baer (1991) did not find any significant results
regarding gender of therapist and gender of client. Both of these variables were included in this research, due to the conflicting findings of these two studies.

The population for the present research consisted of counselors and therapists who were 1993 members of the ACA. Seven hundred counselors, 350 female and 350 male, were randomly selected from the active membership list after members in non-adult work settings, students, retirees, and emeritus were eliminated. The 350 female and 350 male subjects were randomly assigned to one of four groups: 1) male counselors rating ethical behaviors with female clients; or 2) male counselors responding to behaviors with male clients; and 3) female counselors rating ethical behaviors with male clients; or 4) female counselors responding to behaviors with female clients.

Within each of these four groups two sets of surveys were randomly assigned to subjects. Two sets contained Ethics Survey A (female client) and two sets contained Ethics Survey B (male client); the Ethics Survey was always placed first in each survey booklet, the other instruments were randomly ordered. The four sets of survey booklets were printed so that the questionnaire order was randomly changed to prevent a response bias occurring due to a specific order. The only difference between the A and B versions of the forms were the pronouns; on the "male client" forms the pronouns were masculine and on the "female client" forms the pronouns were feminine (see Table 1). The survey booklets were randomly assigned to subjects within each group through the employment of a random number table.
Respondents were requested to complete a survey packet which consisted of five instruments. The Ethics Survey (ES [A or B]) (adapted from Baer, 1991; Borys, 1988) was utilized to collect information on counselor attitudes regarding dual relationship behaviors. It consists of 22 value-neutral descriptors that were rated on a 6-point Likert scale from 5, "always ethical", to 1, "never ethical", and 0, "not sure". The ES was scored by obtaining a total score for each of the respondents’ subscales (Intimate Involvements, Social Involvements, Dual Professional Roles, and Professional Objectivity).

The Therapeutic Stresses Rating Scale (TSRS) (Hellman et al., 1986) consisted of 37 items, of which 26 were actually utilized in the scoring, and each were rated on a 7-point Likert scale. It measures five dimensions of work related stress based on work performed by psychologists, psychiatrists, and social workers. The subscales (dimensions) were: a) Therapeutic Relationship, maintaining vulnerability and personal distance during counseling/therapy; b) Scheduling, scheduling difficulties; c) Professional Doubt, doubts regarding their counseling/therapy; d) Work Overinvolvement, work roles which extend beyond proper limits; and e) Personal Depletion, elements of burnout. Low scores on the subscales indicated low stress and high scores, high or major source of stress.

The AT-20 Scale (AT-20) Ambiguity Tolerance Scale (MacDonald, 1970) was formatted for respondents to mark a "T" or "F" beside each of the 20 items. The instrument was scored for high ambiguity tolerance. High tolerance tends to be expressed by more flexibility and a more openness to differences.
Personal boundaries were measured by the Personal Characteristics Questionnaire (PCQ) (Miller, 1970). Forty-one items were rated on a 7-point Likert scale, however, only 32 of the items were utilized in the actual scoring. Two dimensions of interest were boundary, the ability to keep clear distances from others, and fusion, the tendency to overconnect with others. A high score on boundary indicates clear boundaries and a high score on fusion indicates a strong tendency to merge.

The last instrument utilized in the survey was the Demographic Information Questionnaire (DIQ). It was designed to gather occupational and socio-demographic information for the purpose of examining the representativeness of the sample and to describe the sample.

The Total Design Method (TDM; Dillman, 1978) was utilized to maximize response quality and quantity from the respondent. The first mailing included a survey, a cover letter, a pre-addressed and stamped return envelope, and a postcard which was to be returned under separate cover to indicate that they had completed the survey and to request a summary of the results. One week later a postcard was mailed as a reminder for those who did not return the survey and a thank-you to those who did. The postcard was designed to maintain the respondents' anonymity but, also provided a means to follow-up on nonrespondents. The second mailing of the survey was sent out three weeks later than the original. The survey packet was the same as the original except for the cover letter. The third mailing was sent to all nonrespondents and consisted of a cover letter, the DIQ, and a return envelope. The counselors who did not respond to the survey were requested to provide
socio-demographic information which was utilized to examine differences between the respondents and nonrespondents.

This study was designed to utilize a canonical correlation as the primary analysis. It investigated the relationship of the overall counselor endorsements of ethical behaviors to therapeutic stress, personal boundary preferences, tolerance for ambiguity, gender of counselor, and gender of client. In addition, separate multiple regression analyses were performed to investigate the relationship of each criterion variable to the predictor variables. All analyses were performed on SPSS/PC+, Version 5 (1992a); SPSS for Windows, Release 6 (1993a).

Findings of the Study

The purpose of this study was to examine the relationship of dual role behaviors endorsed by counselors to several counselor characteristics and gender of client. Specifically, the predictive variables were therapeutic stress, tolerance for ambiguity, personal boundary preference, gender of counselor, and gender of client. The summary of the findings are presented in the following parts: representativeness of the sample, description of the sample, factor analysis of the ES, and results by research question.

Representativeness of the Sample

From the total of 485 (69.3%) responses, 449 (64.1%) were utilized for data analysis. The number of responses for the four groups were as follows: female counselors with female clients, 115 (25.6%); female counselors with male
clients, 121 (26.9%); male counselors with female clients, 104 (23.2%); and male counselors with male clients, 109 (24.3%).

Representativeness of the sample was investigated through the utilization of two procedures. First, chi-square and t-test analyses were utilized to ascertain whether early and late respondents were statistically different on eight variables: marital status, ethnicity, sexual orientation, degree, license, work setting, theoretical orientation, and social isolation. The results of the chi-square tests for independence for these selected demographic variables indicated acceptance of the null hypotheses which states that the respondent group (early vs. late) is independent of each of the eight demographic variables. No statistically significant associations were found between the early and late respondents among any of the selected demographic variables. A t-test comparing early respondents and late respondents by age (t(439) = -1.06, p < .291) and years of experience (t(444) = .01, p < .990) indicated no statistically significant difference between the early and late respondents.

Second, chi-square and t-test analyses were utilized to determine whether respondents of completed surveys and nonrespondents (those who returned only the DJQ in response to the third follow-up mailing) differed significantly. The respondents and nonrespondents were analyzed on the eight following variables: marital status, ethnicity, sexual orientation, degree, license, work setting, theoretical orientation, and social isolation. The results of the chi-square tests of independence revealed that there were no statistically significant associations between the respondents and nonrespondents on the selected demographic variables. The t-test analysis comparing respondents to
nonrespondents on age ($t(514) = 1.56, p < .119$) indicated no statistically significant differences (Table 6). However, these two groups did differ significantly on years of experience ($t(96.31) = 2.43, p < .017$). The mean years of experience was significantly higher for the nonrespondents.

Therefore, the results of these analyses indicated that the early and late respondents in this research were similar on the demographic information collected. The respondents and nonrespondents were also similar on the demographic information except for the number of years providing counseling services since the completion of training.

**Description of the Sample**

Characteristics of the sample were based on the information from the DIQ. The data revealed that slightly more female counselors returned completed surveys than male counselors, 236 (52.6%) and 213 (47.4%), respectively. However, slightly more counselors responded with male client forms (235, 52.3%) than female client forms (214, 47.7%). A majority of the respondents identified as Caucasian (89.1%), exclusively heterosexual (86.8%), and married or partnered (73.3%). The average age of respondents was 45 years old and the average number of years experience was 10.

Two-thirds of the respondents held a license, registration, or certificate to practice counseling or therapy. However, less than half of those who were licensed, were actually licensed as counselors (46.6%). Psychology was the second highest category of licensure (7.2%). The majority of the survey respondents (n=397, 88.6%) worked primarily in two settings: Private practice (n=205, 45.8%); colleges and universities (n=104, 23.2%). When given a
forced choice regarding their theoretical orientation, respondents indicated they were mostly humanistic (30%) or cognitive (26.2%). In addition, approximately 70% of the respondents indicated that they were not isolated or mildly isolated.

**Factor Analysis of the ES**

Given that the Ethics Survey provided the main dependent measures for the present study and that the reliability for the first factor was somewhat low, a decision was made to perform a factor analysis. There was a possibility that the results of the Borys' factor analysis (1988) could be sample specific. Therefore, a factor analysis was performed on the ES utilizing principal components analysis which was orthogonally rotated to extract factors. This was performed to examine the number of factors extracted and the loadings of the factors for the sample in the current study.

A four-factor solution resulted from this analysis which was different from the Borys' three-factor solution. All of the loadings interpreted were above the .40 criteria recommended by Stevens (1992) except one which was .39. The factor indices were renamed to appropriately reflect the construct underlying each factor.

Factor I accounted for 29.6% of the total variance. It was composed of behaviors that reflected monetary, personal, and sexual issues. The items regarding client gift giving contain an underlying element of closeness and caring for the counselor/therapist. The other items in factor I also have underpinnings in a personal, intimate relationship. Therefore, this factor was labelled "Intimate Involvements".
Factor II includes items that have extra-therapeutic involvements. Some are incidental, one-time occasions, as described by Borys (1988), and others are possibly more long-term and social in nature. This factor was labelled "Social Involvements". Factor II accounted for 9.1% of the total variance.

Factor III, was the underlying construct for behaviors that placed a counselor in what are typically thought of as dual roles, though not all of these behaviors are necessarily unethical according to the ACA Ethical Standards (1988). This factor was labelled "Dual Professional Roles". Factor III accounted for 7.9% of the total variance.

The last factor, factor IV, accounted for 5.7% of the total variance. This factor, labelled "Professional Objectivity", consisted of referral and client load issues surrounding counseling a friend, relative, or lover of a client. Objectivity and confidentiality are very difficult to maintain and control when a counselor is counseling significant others of a client.

The original research questions were then slightly modified to reflect the results of the four-factor solution from the principal components analysis. Importantly, these changes do not reflect any major conceptual change or statistical procedural change to the study.

Findings by Research Question

Research Question 1

Are the overall ethical behaviors endorsed by counselors dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender factors?
A canonical correlation analysis was conducted to investigate the relationship between the dependent variable set and the independent variable set. In this study the criterion variable set consisted of four variables measuring dual relationship behaviors: Intimate Involvements, Social Involvements, Dual Professional Roles, and Professional Objectivity. The predictor variable set consisted of 10 variables measuring Therapeutic Stress, Personal Boundaries, Ambiguity, and Gender: Therapeutic Relationships, Scheduling Difficulties, Professional Doubt, Work Overinvolvement, Personal Depletion, Boundary, Fusion, Tolerance for Ambiguity, Gender of Client, and Gender of Counselor/Therapist.

It was possible to calculate four canonical functions in this analysis. Three criteria were utilized to decide which canonical functions should be interpreted: the level of statistical significance of the functions, the magnitude of the squared canonical correlations ($R^2_\text{c}$), and the Stewart-Love index of redundancy and the examination of total redundancy. Examination of this information led to the decision to interpret canonical function 1 and 2.

The interpretation of canonical function 1 suggests that female counselors who report having low boundary preference and a high tolerance for ambiguity tend to endorse less dual professional roles as being ethical and more social involvements as being ethical. More specifically, women who endorse more social involvements and less dual professional roles tend to be more organized, make clear distinctions between subordinate and superior, and tend to be more open to new possibilities and situations. These women are also more likely to believe that accepting a client's invitation to a special
occasion, becoming friends with a client after termination, and going out to eat with a client are more ethical. They are less likely to provide counseling to a current employee, student, supervisee, or employ a client.

The findings of canonical function 2 suggest that female counselors/therapists who tend to report stress from professional doubt and stress in maintaining therapeutic relationships in their practice endorse less dual relationship behaviors overall. In particular, they tend to strongly consider intimate involvements and professional objectivity involvements to be unethical. Specifically, women who feel frustrated with a lack of therapeutic success, doubt the efficacy of counseling/therapy, and feel physically exhausted and emotionally depleted tend to endorse less dual role behaviors. These women are more likely to endorse all items on the ES as being "never ethical". Conversely, those respondents who endorse less social involvements with clients and more dual professional roles, are more likely to be male counselors who score lower on tolerance of ambiguity and higher on boundary preference.

Total redundancy indicated that seven percent of the total variance in the dependent variable set could be predicted or explained by the relationship between the dependent variable set and the independent variable set, if all the functions were interpreted. The redundancy index indicated that 1.7% of the variance in the dependent variable set could be explained by the first canonical function and an additional 3.9% for the second canonical function. The relationship of overall endorsement of dual role behaviors to therapeutic stress, tolerance for ambiguity, personal boundary preference, and gender is weak. Also, the contribution of the predictor variables to the criterion variables is small,
considering that only 5.6% of the variance in the dependent variable set can be explained by the two canonical variates.

**Research Question 2**

*Are the intimate involvement behaviors endorsed by counselors dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender factors?*

A multiple regression analysis was utilized to investigate the relationship between the endorsement of intimate involvements by counselors and therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender. The multiple coefficient of correlation (R) was .24 which indicated a weak relationship between the dependent variable and a linear combination of the independent variables.

Only 6 percent of the variance in the endorsement of intimate involvements was accounted for by the linear combination of the predictor variables. However, the model was statistically significant when all the variables were forced into the equation simultaneously ($R^2 = .06, F(10, 354) = 2.12, p < .02$). Holding all other independent variables constant, males tended to endorse more intimate involvements as ethical. Also, counselors who maintained less distance between self and others tended to endorse more intimate involvements.

**Research Question 3**

*Are the social involvement behaviors endorsed by counselors dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender factors?*
A multiple regression analysis was performed with the predictor variables entering the equation simultaneously. In this approach, the predictor variables did not account for a significant proportion of the variance in the criterion variable \( R^2 = .05, F(10, 315) = 1.54, \ p < .12 \). In other words, the model was not statistically significant at the alpha level of .05 and, therefore, was not interpreted.

**Research Question 4**

Are the dual professional role behaviors endorsed by counselors dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender factors?

The Dual Professional Roles subscale was regressed on all the predictor variables to investigate their relationship. Findings from the simultaneous multiple regression indicated a weak relationship \( R = .28 \) between the dependent variable and the linear combination of the independent variables. With all the independent variables in the equation, a small amount of the variance in the dependent variable \( R^2 = .08 \) was accounted for by the linear combination of the independent variables. The model was significant \( F(10, 356) = 2.95, \ p < .001 \). Two variables contributed significantly to the regression, holding all other independent variables constant; Fusion and Gender of Therapist. As the endorsements of dual professional roles increase, the more likely it will be that the counselor is a male. Also, counselors who tend to endorse more dual professional roles as being ethical are more likely to blur boundaries.
Research Question 5
Are the professional objectivity behaviors endorsed by counselors dependent on therapeutic stress, personal boundary preference, tolerance for ambiguity, and gender factors?

Another multiple regression was performed to investigate the relationship of the dependent variable to the independent variables. The multiple R value, .23, indicates a weak relationship between Professional Objectivity and the linear combination of the independent variables. Only five percent of the variance in the dependent variable could be accounted for by the independent variables. The regression model was significant ($R^2 = .05, F (10, 382), = 2.12, p < .02$). The most important variables contributing to the equation, holding all other independent variables constant were Fusion and Gender of Therapist. The more endorsements of Professional Objectivity involvements, the more likely they will be made by male counselors. Also, a slight increase in fusion scores are associated with higher professional objectivity endorsements. The regression assumptions were examined as were the residuals.

Conclusions

The current study contributes new information to the literature on ethics by extending prior research in the field. This section provides nine major conclusions related to the research questions investigated in this research.

1. The results of the canonical correlation analysis indicated that the relationship between the criterion variable set and the predictor variable set was very weak. Neither canonical function had much relative power to predict or
explain relationships. In addition, only 5.6 percent of the total variance in the dependent variable set was accounted for by the linear combination of the independent variable set. Therefore, even though the relationship was statistically significant, it does not explain enough of the variance to be meaningful.

The present study may be the first time that ethics data on dual relationships has been inferentially manipulated to investigate variable sets. Only one study, an unpublished dissertation, was located that utilized a design which investigated the proportion of variance in dual role social situations accounted for by demographic information, reasons for the subjects' responses, and personality variables (Stewart, 1991). She found that 27.8 percent of the variance in the total ethical decision making score was accounted for by the linear combination of the independent variables.

Specific conclusions based upon a comparison of results in Stewart (1991) and the present study are not possible due to the different data gathered. However, it is possible to draw an overall conclusion. In particular, the independent variables utilized in the present study were variables that were found significant in previous research regarding dual relationships. These were viewed as the most important variables studied to date. Given this, the expectation was that more of the variance in the criterion variables would have been explained by the predictor variables. The variance accounted for in the present study as well as in the Stewart study (1991) was small. Therefore, there must be one or more variables (i.e., anxiety, other personality measures,
and impulse control) that are important to the endorsement of dual role
behaviors that have not yet been investigated.

2. The results of the canonical correlation variates one and two
supported findings in the literature regarding gender differences in the
endorsement of ethical behaviors (Holroyd & Brodsky, 1980; Pope, 1990b), and
in particular to dual role behaviors (Borys & Pope, 1989). The canonical variate
one findings suggested that female counselors who reported having low
boundary preference and high tolerance for ambiguity were less likely to
endorse dual professional roles as being ethical. Conversely, those counselors
who tended to endorse more dual professional roles and less social
involvements were more likely to be males with high boundary preference and
low tolerance of ambiguity.

3. In addition to gender, tolerance for ambiguity was a significant
variable in this research, however, it appeared to be more related to boundary
preference than to therapeutic stressors. Due to the design of the statistical
procedure, it remains unclear if tolerance for ambiguity was acting as a
moderating variable for boundary preference, for therapeutic stress, or if it was
an important contributor on its own. Previous to this study, it was thought that
the greater the tolerance for ambiguity, the more counselors/therapists would
endorse ethical behaviors. However, the results of the canonical correlation in
the present study regarding tolerance for ambiguity were to the contrary. This
appears to be the first study investigating ambiguity with regards to the
endorsement of ethical behaviors, therefore, it is not possible to provide a
comparison to other research findings. Further research is recommended given its important contribution in this research.

4. The findings for boundary preference were also important in the present research. Women who engaged in less structured interactions and had greater ambiguity tolerance, tended not to provide counseling/therapy to employees, supervisees, or enroll a client in their class. However, they were more likely to go out to eat with a client, become friends with a client after counseling/therapy, or accept an invitation to a clients' special occasion. Males who were more rigid (intolerant) and have higher boundaries (more defended) tend to endorse less social involvements but more dual professional roles. Elements of socialization could play a part in the findings of this variate, however, additional research is needed to investigate whether this is a valid hypothesis.

Baer (1991) found conflicting results when examining differentiation and stress together. It may be possible that stress does not have an influence on boundary preference.

The second canonical variate finding in the present study indicated that female counselors who reported higher stress from professional doubt and from maintaining therapeutic relationships were less likely to endorse any of the ethical behaviors. Whereas, men who did not report stress regarding professional doubt and maintaining therapeutic relationships were more likely to endorse more ethical involvements on all the subscales. It may be possible that the more difficult it is to maintain therapeutic relationships, the more professional doubt develops, and the less the counselor is willing to risk
engaging in more unethical behaviors with clients. Hellman et al. (1987) found that therapists who reported higher fusion also reported more stress in therapeutic relationships and professional doubt. Even though the present study’s second canonical variate results did not find boundary preference to be statistically significant, stresses related to maintaining therapeutic relationships and professional doubt did contribute significantly.

5. The multiple regression analyses conducted in the present study confirm the significant differences for gender found in the canonical correlation. Because the multiple regressions examined one dependent variable at a time, it is possible to determine which variables contributed to each ethics subscale. Male counselors tended to endorse more ethical behaviors for intimate involvements, dual professional roles, and professional objectivity; females tended to endorse less ethical behaviors on these subscales.

It is not possible to directly compare these findings in the present study with those of Borys (1988) and Baer (1991) due to the differences in the factor solutions. However, these results do appear to confirm findings from previous research and from ethics committee reports which have indicated that males tend to endorse more behaviors overall as being ethical and are reported more as violators of ethics codes more than females (AACD, 1991; Borys & Pope, 1989; Holroyd & Brodsky, 1980; Pope, 1990b).

6. There were differences between the canonical correlation and the multiple regression findings on boundary preference. In the first multiple regression (research question 2), counselors with low boundary preference were more likely to endorse more intimate involvements. However, the third
and fourth multiple regressions indicate fusion as an important contributing variable. In particular, higher fusion contributed significantly to more endorsements of dual professional roles and less fusion contributed to more endorsements of professional objectivity. If one considers fusion and boundary on a continuum, these findings could be seen as congruent. However, if they are indeed separate orthogonal scales, then the results are not consistent with the canonical findings. The incongruency could either be due to instrument measurement error or the difference of boundary preference contribution when all the variables are examined together, such as in the canonical. It is very possible that when the intercorrelations of the variables were taken into consideration a different result occurred on this dimension.

In previous studies, boundary preference has been explored in relation to family systems theory (Alber, 1991; Baer, 1991). Baer (1991) found mixed results, however, Alber (1991) found that lower differentiation was associated with higher anxiety and stress.

7. Conceptually, the PBQ manual and the related research does not appear to adequately address what it means for a person to have a high score on boundary and, at the same time, to have a high score on fusion. Theoretically, if the factors are orthogonal (a correlation matrix of the retained factors was not provided) this situation could happen and, indeed, has occurred in the results of the present study.

Questions can also be raised regarding what it means for a practitioner to endorse items high or low on each factor in terms of: how a counselor/therapist reacts to clients or certain types of clients in the therapeutic
relationship; how they may react in the treatment of different personality disorders, and; what does it actually mean for a clinician to have high boundaries and to endorse a high number of items as being ethical? Specifically, how should a researcher interpret a person’s score of high on boundary (choosing items indicating more distance from clients) who also endorse the kind of dual relationship behaviors that indicate unethical behaviors and considerable boundary crossing?

8. The findings of the present study support the general trend that men and women tend to react to ethical situations in different ways. It may be possible that socialization plays a more than subtle role. The results of canonical analysis tends to support the work of Gilligan (1982). Her own words state it most appropriately as she writes:

   From the different dynamics of separation and attachment in their gender identity formation through divergence of identity and intimacy that marks their experience in the adolescence years, male and female voices typically speak of the importance of different truths, the former of the role separation as it defines and empowers the self, the latter of the ongoing process of attachment that creates and sustains the human community (p. 156).

9. The Ethical Standards (AACC, 1988) of ACA do not directly relate to 12 of the 22 items listed on the Ethics Survey. Some of these items include: "Being sexually attracted to a client"; "Going out to eat with your client"; "Accepting a gift worth under $10 from your client"; and "Engaging in sexual activity with your client after termination". Since an item analysis was not part of
the present study it is difficult to tell if any significant differences occurred between the items addressed by the ethical codes and those not addressed. This question may need to be studied further to investigate whether there would be more counselor endorsements for items where there is ambiguity in the codes or where the codes are silent. Another recommendation would be to compare the laws in various states to the ethical codes. Then, investigate how different the endorsement responses are depending on how ambiguous the laws or codes are in each state.

**Implications**

This study has provided empirical data on the relationship of dual role behaviors to therapeutic stress, boundary preference, tolerance for ambiguity, and gender. The major implication of this research is the finding that there seems to be some other variable or variables that contribute more to dual role behaviors than the ones investigated. Given that the variables in the present research were chosen from those previous studies deemed as significant, it is thought that other important contributing variables are ones which have not been previously studied in connection with dual role behaviors. Previous studies assumed that the contribution of these variables was substantial, however, based on the present study it appears to be small. Because the present research investigated the relationship and contribution of the variable sets, it has provided an important contribution to the literature. This information could only have been obtained through an examination of data through a different perspective than has been utilized in previous research.
A second implication is that the Ethics Survey (an adaption of Borys’ TPS, 1988) appears to be a useful instrument in this kind of research. The reliability was good and even though the factor analysis in the present study resulted in different factor loadings than those of Borys, the factor loadings were solid.

Third, the results from the present study support previous findings of counselor gender differences in regard to ethical behaviors. However, client gender differences were not found to be statistically significant. Baers’ (1991) findings also supported prior research on gender bias in that male therapists reported more ethical involvements than female therapists, however, her results suggested that male therapists endorsed more involvements for male than female clients. Previous research supports the finding that male therapists endorse more involvements than female therapists with male clients (Bouhoutsos et al., 1983; Hoiroyd & Brodsky, 1977; Gabbard & Menninger, 1991) but typically, male therapists have endorsed more behaviors with female rather than male clients.

**Recommendations for Future Research**

Eight research recommendations are suggested based on the findings of this research.

1. Future research should investigate variables, in relation to ethical endorsements, which have not previously been studied within the disciplines of counseling, counseling psychology, clinical psychology, and psychiatry. Other variables may surface through a review of literature in related disciplines. One
such variable might be impulse control because it appears closely tied to ethical
decision making. Another variable to explore may be anxiety rather than stress.
Anxiety and stress, are two related but separate variables. Last, personality
measures different than those utilized in the present research should also be
considered for further research.

2. Additional research is needed to not only investigate new variables but
also to replicate the present research with the same and/or similar populations.
For example, the present research could be replicated with samples of
psychiatrists, psychologists, social workers or counselors working with children.
Additional research is recommended because little variance in the criterion
variable set was explained by the predictor variable set. It appears as if
previous research in ethics was based on the assumption that these variables
captributed significantly to ethical behaviors and as a result there was a reliance
on the findings to indicate whether there were main effects or interactions of
certain variables.

3. If the Ethics Survey is utilized in future research it is recommended that a
factor analysis be performed because the factors may be sample specific. The
factors are dependent on the items included in the survey. More specifically, it
is also recommended that the social bias question "Being sexually attracted to a
client" be excluded and replaced with another item such as "Filing an ethics
complaint against a colleague" (Gibson & Pope, 1993) or any other item that
has previously been endorsed as either overwhelmingly ethical or unethical.
This item seemed to be the most confusing to the respondents and several
made comments that it was not a behavior and could not be rated. Therefore,
the new item should be a behavior that would be accepted or rejected by a majority of respondents.

4. Tolerance for ambiguity does seem to play a role in the endorsement of ethical behaviors. Further research is needed to investigate the relationship of ethical behaviors to tolerance for ambiguity. It would also be important to examine the relationship of ambiguity tolerance to boundary preference, especially to examine its role as a moderating variable.

5. Future research should also be designed to explore the role of boundary preference in the endorsement of ethical behaviors. The Personal Boundary Questionnaire provides a unique perspective of boundary and fusion as two separate factors instead of viewing both as existing on a continuum. The former perspective may prove to be useful in the examination of ethical issues. First, however, additional research is needed to conceptually clarify the meaning and interpretation regarding the boundary preference dimensions.

6. Another avenue for further research would be to explore the role and influence of socialization on men and women in relation to the differential endorsement of ethical behaviors. This is especially important given the increasing evidence in the dual relationship literature that men and women do view ethics from different perspectives at least on some of the ethics factors. For example, utilization of the BEM Inventory (Bem, 1978) may provide useful information regarding sex roles in relation to the endorsement of dual role behaviors.

7. Given that legal ramifications in various states may hamper honest reporting of certain ethical behaviors, it is recommended that a study be
designed to investigate the effects of laws vs. ethical codes. One procedure would be to select and investigate a sample from a state where certain dual role behaviors are listed as a felony and also a sample from a state where it is not. This approach may provide differences between the effects on endorsement of ethical issues.

8. In future research, it may be useful to include selected demographic variables (such as age, years of experience, or amount of training/education in ethics) in the multivariate analyses to investigate the contribution or relationship to the criterion variables.
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May 7, 1993

Dear Colleague:

There are little data available concerning certain therapeutic practices which fall into the "gray" areas not addressed by law or professional ethics codes. Therefore, a national study is underway to seek your opinion on the ethicality of various therapeutic behaviors in relation to certain counselor characteristics.

You have been randomly selected from a representative sample of counselors who are members of the American Counseling Association and who work primarily with adult clients. In order that the results truly represent the attitudes of the ACA membership, it is important that each questionnaire be completed and returned. It is also important that we have about the same number of men and women participating in this study. This survey will only take approximately 20 minutes to complete.

We are aware of the potentially sensitive nature of some survey items. For this reason, you may be assured of complete anonymity. There is no way we can identify from whom the questionnaires are returned as no coding procedures have been utilized. Please do not place your name on the questionnaires. Instead, we ask that you print your name neatly on the enclosed postcard and mail it back separately so that we may remove your name from our mailing list. Only the questionnaires should be returned in the postage free envelope.

Results will be disseminated through professional and scholarly sources. They will be reported in an aggregate form without reference to individuals or institutions. We anticipate the results of this study will be useful to ACA in evaluating its ethical standards, as well as, to individual counselors making complicated counseling decisions. If you would like to receive a summary report please indicate this by checking the box on the enclosed postcard. We would be most happy to answer any questions you might have regarding this study. Please feel free to write or call us at the above address or phone number.

We wish to express our appreciation in advance for your valuable time and willingness to participate in this important study concerning the counseling profession.

Sincerely,

Jeanette Belz, M.A.
Doctoral Candidate

James V. Wigtil, Ed.D.
Committee Chairperson
APPENDIX B

DEMOGRAPHIC INFORMATION QUESTIONNAIRE (DIQ)
DEMOGRAPHIC INFORMATION QUESTIONNAIRE

Q-1  Gender:  (Circle number of your answer)
     1  Male
     2  Female

Q-2  Ethnic origin: (Circle number)
     1  African American
     2  Asian
     3  Native American
     4  Hispanic
     5  Caucasian
     6  Other (specify) ____________________

Q-3  Age:  _____ Years.

Q-4  Marital Status: (Circle number)
     1  Never married
     2  Married\Partnered
     3  Cohabitating
     4  Divorced
     5  Separated
     6  Widowed

Q-5  Sexual Orientation: Would you describe yourself as: (Circle number)
     1  Exclusively heterosexual
     2  Heterosexual with homosexual experiences
     3  Bisexual
     4  Homosexual with heterosexual experiences
     5  Exclusively homosexual

Q-6  Highest degree: (Circle number)
     1  Doctorate
     2  Education Specialist
     3  Master's
     4  Bachelor's
     5  Associate/Certificate
     6  Other (specify) ____________________

Q-7  Do you hold a state or national license, certification or registration?
     1  Yes
        If yes, please specify (i.e., Licensed Professional Counselor, National Certified Counselor, Licensed Psychologist, etc.) ______________________________
     2  No

Q-8  Work setting: (Circle the number best describing your work setting)
     1  College\University
     2  Private Practice\Counseling
     3  Community\Mental Health Agency
     4  Rehabilitation Program\Agency
     5  Career Development Center
     6  Government
     7  Corrections Facility
     8  Business\Industry
     9  Elem.\Jr. Hi.\High School
     10  Military Installation

Q-9  Have you provided counseling/therapy services at any time within the last 5 years?
     1  Yes
     2  No

Q-10 How many years have you provided counseling/therapy services since the completion of your educational training?  _____ Years.

Q-12 Most counselors\therapists are guided in their clinical work by a particular theoretical orientation. Please indicate which theoretical orientation has the most influence on your counseling\therapy work with clients:
     1  Behavioral
     2  Cognitive
     3  Humanistic (e.g., Gestalt, Existential)
     4  Psychodynamic
     5  Other (specify) ____________________

Q-13 While working in the primary setting in which you provide counseling/therapy, how socially isolated do you feel?
     1  Extremely isolated
     2  Moderately isolated
     3  Mildly isolated
     4  Not at all isolated
APPENDIX C

ETHICS SURVEY: A (FEMALE)
**SURVEY FORM: ETHICS (A)**

Below are listed a number of behaviors which counselors/therapists may engage in as part of their clinical practice. For each behavior, please indicate, by circling the appropriate number, whether you consider it: (5) ALWAYS ETHICAL, (4) ETHICAL UNDER MOST CONDITIONS, (3) ETHICAL UNDER SOME CONDITIONS, (2) ETHICAL UNDER RARE CONDITIONS, (1) NEVER ETHICAL, OR (0) IF YOU ARE NOT SURE.

In responding to each item, please consider only counseling/psychotherapy with **ADULT FEMALE** clients. Unless otherwise indicated, items refer to a counselor's/therapist's behavior with clients he or she is currently seeing.

<table>
<thead>
<tr>
<th>BEHAVIOR</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepting a gift worth under $10 from your client</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accepting a client’s invitation to a special occasion (e.g., her wedding or graduation)</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Providing individual counseling/therapy to a friend of your ongoing client</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Selling a product to a client</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Becoming friends with your client after termination</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accepting a gift worth over $500 from your client</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Providing counseling/therapy to your current employee</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inviting clients to your office/clinic open house</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accepting a handshave offered by your client</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Providing counseling/therapy to a current student or supervisor</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Discovering details of your current personal stresses to your client</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Being sexually attracted to a client</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Employing your client</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Going out to eat with your client</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Buying goods or services from your client</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Engaging in sexual activity with your current client</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inviting your client(s) to a personal party or social event</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Providing individual counseling/therapy to a relative of your ongoing client</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Providing a service or product as payment for counseling/therapy</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Engaging in sexual activity with your client after termination of treatment</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Providing individual counseling/therapy to a lover of your ongoing client</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Allowing your client to enroll in your class for a price</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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APPENDIX D

ETHICS SURVEY: B (MALE)
**SURVEY FORM: ETHICS (B)**

Below are listed a number of behaviors which counselors/therapists may engage in as part of their clinical practice. For each behavior, please indicate, by circling the appropriate number, whether you consider it: (5) ALWAYS ETHICAL, (4) ETHICAL UNDER MOST CONDITIONS, (3) ETHICAL UNDER SOME CONDITIONS, (2) ETHICAL UNDER RARE CONDITIONS, (1) NEVER ETHICAL, OR (0) if you are NOT SURE.

In responding to each item, please consider only counseling/psychotherapy with **ADULT MALE** clients. Unless otherwise indicated, items refer to a counselor/therapist's behavior with clients he or she is currently seeing.

<table>
<thead>
<tr>
<th>BEHAVIOR</th>
<th>ALWAYS ETHICAL</th>
<th>ETHICAL UNDER MOST CONDITIONS</th>
<th>ETHICAL UNDER SOME CONDITIONS</th>
<th>ETHICAL UNDER RARE CONDITIONS</th>
<th>NEVER ETHICAL</th>
<th>NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepting a gift worth under $10 from your client.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Accepting a client's invitation to a special occasion (e.g., his wedding or graduation).</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Providing individual counseling/therapy to a friend of your ongoing client.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Selling a product to a client.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Becoming friends with your client after termination.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Accepting a gift worth over $50 from your client.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Providing counseling/therapy to your current employee.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Inviting clients to your office/clinic open house.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Accepting a handshake offered by your client.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Providing counseling/therapy to a current student or supervisee.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Disclosing details of your current personal stresses to your client.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Being sexually attracted to a client.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Employing your client.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Going out to eat with your client.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Buying goods or services from your client.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Engaging in sexual activity with your current client.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Inviting your client(s) to a personal party or social event.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Providing individual counseling/therapy to a relative of your ongoing client.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Accepting a service or product as payment for counseling/therapy.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Engaging in sexual activity with your client after termination of treatment.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Providing individual counseling/therapy to a peer of your ongoing client.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Allowing your client to enroll in your class for a grade.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

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APPENDIX E

POSTCARD REQUESTING RESULTS
I have returned my survey packet separately.

______________________________
Please print your name here

☐ Check here if you wish to receive a summary report on this study.

Thanks again for your help with this important study.
APPENDIX F

FOLLOW-UP POSTCARD
May 14, 1993

Last week a survey packet seeking your opinion on the ethicality of therapeutic practices in relation to counselor characteristics was mailed to you. Your name was randomly selected from the membership of the American Counseling Association.

If you have already completed and returned the survey to us please accept our sincere thanks. If not, please do so today. Because it has been sent to only a small, but representative sample of counselors, it is extremely important that yours also be included in the study if the results are to accurately represent the attitudes and characteristics of counselors.

If by some chance you did not receive the survey packet, or it got misplaced, please call me right now, collect (614-497-3409) and I will get another one in the mail to you.

Sincerely,

Jeanette Benz, Ph.D.
Doctoral Candidate

James V. Wight, Ed.D.
Committee Chairperson
APPENDIX G
SECOND COVER LETTER
May 28, 1993

Dear Colleague:

About three weeks ago we wrote to you seeking your opinion on the ethicality of certain therapeutic practices in relation to counselor characteristics. As of today we have not received your completed survey.

This research has been undertaken because of the lack of information on counselors' attitudes and characteristics. We anticipate this study to fill a void in the research concerning counselors and for it to be useful to the American Counseling Association (ACA) in evaluating its ethical standards. This survey will only take approximately 20 minutes to complete.

We are writing again because of the significance each questionnaire has to the usefulness of this study. It is essential that the survey be returned to reflect the opinions of individuals in positions similar to yours. In the event that the survey has been misplaced, a replacement is enclosed for your use.

We are aware of the potentially sensitive nature of some survey items. For this reason, you may be assured of complete anonymity. There is no way we can identify from whom the questionnaires are returned as no coding procedures have been utilized. Please do not place your name on the questionnaires. Instead, we ask that you print your name neatly on the enclosed postcard and mail it back separately so that we may remove your name from our mailing list. Only the questionnaires should be returned in the postage free envelope.

Your cooperation in participating in this important study is greatly appreciated.

Sincerely,

[Signatures]

Jeanette Belz, M.A.
Doctoral Candidate

James V. Wrigth, Ed.D.
Committee Chairperson
APPENDIX H

PERMISSION LETTERS
January 31, 1993

Jeanette Belz, M.A.
4960 Meadowbrook Dr.
Columbus, OH  43207

Dear Jeanette:

I am writing you this note to confirm that I give you my permission to adapt and use my Therapeutic Practices Survey for your dissertation study. This permission is given, in accordance with copyright laws, provided that you note on your adaptation of the survey, "Adapted from Therapeutic Practices Survey, copyright 1985 by Debra Borys. Used with permission.", or dictionary abbreviations of same.

As we discussed, I am enclosing a copy of my recent article on nonsexual dual relationships for your interest.

I would appreciate if you would send me the author’s name and address for the Personal Boundary Questionnaire, as you mentioned. I also ask those who use my survey, or an adaptation of it, to please send me an abstract of their findings, so that I may keep abreast of new research in this area. Would you be so kind to do so when you have completed your study?

Best wishes with your study and thank you in advance for the material you will be sending me, per above.

Sincerely,

[Signature]

Debra S. Borys, Ph.D.
Jeanette Belz, M.A.
4960 Meadowbrook Dr.
Columbus, Ohio 43207

Dear Jeanette:

I am writing this letter to confirm that I give you my permission to adapt and use the Ethics and Utility Survey Forms for your dissertation study. Please provide this permissions information on the bottom of your adaptation: "Adapted from Ethical Assessment and Utility Assessment Surveys, copyrighted 1991. Used with permission."

Sincerely,

Barbara Baer, Ph.D.

Barbara Baer, Ph.D.
Ms. Jeannette Belz
Columbus, Ohio

Dear Jeannette,

This letter is to acknowledge my granting you permission to use my measures of therapist stress and stressful patient behaviors. Good luck--please send me results upon completion of your study.

Sincerely,

Barry A. Farber, Ph.D.
Professor
March 3, 1993

Jeanette Belz
Doctoral Candidate
4960 Meadowbrook Drive
Columbus, OH 43207

Dear Ms. Belz:

Thank you for your persistence in tracking me down in your pursuit of the expanded versions of rating scales I used in my dissertation. I am honored that my work is still relevant and would be pleased if you were to use my expanded versions of the Stressful Patient Behaviors Questionnaire and the Stress of Work Questionnaire. I have also enclosed portions from my methods sections and results that describe the questionnaires further. The scoring was submitted raw for each question and then included in various multivariate analyses. Please contact me if I can provide any further information.

Sincerely,

Irving Hallman, PhD

2200 L Street
Sacramento, CA 95816
(916) 442-7129

P.S. In response to your question about scoring, there is no total score for these scales. Various items fall under different factors. If you have questions, feel free to call.
2200 L Street
Sacramento, CA. 95816

March 19, 1993

Jeanette Belz, M.A.
Doctoral Candidate
4960 Meadowbrook Drive
Columbus, Ohio 43207

Dear Ms. Belz:

I have received your letter requesting an adaption of the expanded
versions of the Stress of Work and Stressful Patient Behaviors
Questionnaires. You have my permission to use counselor\therapist
and counseling\psychotherapy where the words therapist and
psychotherapy now appear on the instruments. I understand how this
may be helpful with the sampling you are using.

Sincerely,

Irving Hellman, Ph.D.
As Jeanette Belz.

As per your request.

You have my permission to use the tools.

Jeanette Belz

PhD
Ms. Jeannette Belfz
4960 Meadowbrook Drive
Columbus, OH 43207

Dear Ms. Belfz:

With regard to your request to use the AT20 Scale in your dissertation, we grant you permission to do so.

A. F. MacLeod, who is since deceased, constructed the scale while an employee of our Rehabilitation Research and Training Center here at West Virginia University.

It would probably be a good idea for you to send a letter to Psychological Reports asking their permission as well, since they may have the copyright.

Best of wishes with your dissertation project.

Yours sincerely,

Richard T. Walls
Professor of Educational Psychology
and Director of Research
Facsimile Transmittal Form

Date: 2/8/93

To: Jeanette Belz
Ohio State University
(614) 292-4255

From: Valerie Brown
Manager, Rights + Permissions
Duke University Press
(919) 684-8644

Re: Permission granted as outlined on attached letter. Note:

Please add to the citation:

"Copyright Duke University Press.
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Good luck with your research.

Valerie Brown

This document consists of 2 pages including this cover sheet. If you have any questions or transmission problems, call 919 684-3171.
Ms. Jeanette Belz, M.A.
4960 Meadowbrook Dr.
Columbus, Ohio 43207

Dear Ms. Belz:

This letter is to follow up our conversation of Feb. 1, 1993. I give you permission to use the Rydell-Rosen Ambiguity Tolerance Scale as part of the AT-20 developed by MacDonald. I also will give you permission to use 2 items from the Rydell-Rosen scale as examples of items contained in the scale. My part of the reproduction permission appears correct and should be credited in the use of the scale.

Sincerely,

Susan T. Rydell

Susan T. Rydell, Ph.D.
February 12, 1993

Ms. Jeannette Belz
4960 Meadowbrook Drive
Columbus, OH 43207

Dear Ms. Belz:

Under the following conditions, we are pleased to grant permission to reproduce Table 4 on page 151 of the following article for use in collecting your dissertation research and citing two examples in your methodology section of your dissertation. The citation must read:

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Sincerely,

Carol H. Ammons, Ph.D.
Editor

CC: Dr. Susan T. Rydeell
Department of Psychology
University of Minnesota
75 East River Road
Minneapolis, MN 55455

P.S. Note our permission covers only Items 1-16. You must also contact Consulting Psychologists Press and Duke University Press as indicated in our letter of January 25, 1993 and the footnote to Table 4 on page 151.
Dear Jeannette:

Please forgive this handwritten note. I've simply been too busy to get to the computer! Thanks for the info on Dr. Miller.

It is fine for you to print the adapted therapeutic practices survey forms in your dissertation.

The citation is:


Good luck on the rest of your project.

Debra
Ms. Jeanette Belz
4960 Meadowbrook Drive
Columbus, OH 43207

Dear Ms. Belz:

We acknowledge receipt of your letter written on January 11, 1993 in which you inquire about the Ambiguity Tolerance Scale published in an article by Dr. A. F. MacDonald, Jr. in Psychological Reports, 1970, 26, 791-798.

Enclosed you will find a photocopy of page 793 of that article where you will notice the note at bottom of Table 1 highlighted for your reference. You must contact each of these authors and request permission to reproduce the items, as Dr. MacDonald did in 1970. The permissions information must then appear, as specified by each publisher, on all copies of this scale which you produce for your dissertation research and in the dissertation itself, if the scale will appear there as well.

We trust this information will start you down the path to obtaining the proper permission from all sources.

Sincerely,

Carol H. Ammon, Ph.D.
Editor

CHA/srh

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These policies are proposed on a trial basis and will be followed until further notice.

C. H. Anderson, Editor
R. B. Anderson, Editor

January 1, 1978
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Customer Number K-13-70
Invoice Number 10-35-2-9
Permission Code 111

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Date ____________

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By __________________________
Jeanette Belz, M.A.

Date ____________
PERMISSION AGREEMENT
ADDENDUM

July 7, 1993

Jeanette Belz
4960 Meadowbrook Drive
Columbus, Ohio 43207

Dear Ms. Belz,

In response to your request of May 25, 1993, upon receipt by Consulting Psychologists Press, Inc., of this signed letter and concurrent payment, permission is granted to you to modify and reproduce 502 additional copies of California Psychological Inventory for a reproduction fee of 502 copies x .10 = $50.20 total, in addition to the 700 copies reproduced under the Permission Agreement dated March 19, 1993 between Jeanette Belz and Consulting Psychologists Press, Inc. This letter dated July 7, 1993 is attached as a rider to the Permission Agreement dated March 19, 1993. This rider shall automatically terminate upon violation of this rider including, but not limited to, failure to pay the Permission Fee or by failure to sign and return the rider within 45 days from July 7, 1993.

CONSULTING PSYCHOLOGISTS PRESS, INC.

By

Lisa Simpson - Permission Specialist

Date July 19, 1993

I AGREE TO THE ABOVE CONDITIONS

By

Jeanette Belz

Date July 12, 1993
APPENDIX I

FOLLOW-UP LETTER TO NON-RESPONDENTS
June 21, 1993

Dear Colleague:

We are writing to you about our survey on the ethicallity of therapeutic practices in relation to counselor characteristics. We did not receive a postcard indicating that you returned the survey, therefore, we are asking you to take approximately 2 minutes to fill out the 13 brief items on the Demographic Information Questionnaire. Your response will provide us with needed data to permit a comparison of the demographic data on non-respondents with respondents and assess the external generalizability of our study. Please do not place your name on the questionnaire. You may return it in the self addressed, stamped envelope which is enclosed for your convenience. If you have completed the survey and returned it please do not fill out this form.

Thank you for your valuable time.

Sincerely,

[Signatures]

Jeanette Belz, M.A.
Doctoral Candidate

James V. Wigtil, Ed.D.
Committee Chairperson
APPENDIX J

POSTAGE NOTE TO
FOREIGN COUNTRY RESPONDENTS
**PLEASE NOTE:** Due to the differences in currency and postal systems, prepaid United States postage could not be used to return the completed survey from your country to the U. S. We have included an envelope addressed to The Ohio State University which you may use to return the completed survey. However, you must purchase stamps from your country for the appropriate amount and place them on the envelope and postcard (place your own country’s postage over the U. S. stamp on the postcard). We feel that your input is very important, so we will reimburse you the amount of the survey postage and the postcard mailing cost. Please indicate on the postcard how much (in U. S. currency) the postage cost you to mail the survey and postcard back to us and we will send you a reimbursement for this. We regret the inconvenience but this seemed to be the best way to include you in the study given the differences in postal requirements. Thank you in advance for completing the survey and postcard enclosed.
APPENDIX K

POSTCARD TO
FOREIGN COUNTRY RESPONDENTS
I have returned my survey packet separately.

Please print your name here

☐ Check here if you wish to receive a summary report on this study.

Thanks again for your help with this important study.

Postage Reimbursement $
APPENDIX L

ACA ETHICAL STANDARDS FOR COUNSELORS CONCERNING DUAL RELATIONSHIPS (AACD, 1988)

A.2 The member has responsibility both to the individual who is served and to the institution within which the service is performed to maintain high standards of professional conduct. The member strives to maintain the highest levels of professional services offered to the individuals to be served. The member also strives to assist the agency, organization, or institution in providing the highest caliber of professional services. The acceptance of employment in an institution implies that the member is in agreement with the general policies and principles of the institution. Therefore the professional activities of the member are also in accord with the objectives of the institution. If despite concerted efforts, the member cannot reach agreement with the employer as to acceptable standards of conduct that allow for changes in institutional policy conducive to positive growth and development of clients, then terminating the affiliation should be seriously considered.

A.8 In the counseling relationship, the counselor is aware of the intimacy of the relationship and maintains respect for the client and avoids engaging in activities that seek to meet the counselor's personal needs at the expense of that client.

B.11 The member may choose to consult with any other professionally competent person about a client. In choosing a consultant, the
member must avoid placing the consultant in a conflict of interest situation that would preclude the consultant’s being proper party to the member’s efforts to help the client.

B.13 When the member has other relationships, particularly of an administrative, supervisory, and/or evaluative nature with an individual seeking counseling services, the member must not serve as the counselor but should refer the individual to another professional. Only in instances where such an alternative is unavailable and where the individual’s situation warrants counseling intervention should the member enter into and/or maintain a counseling relationship. Dual relationships with clients that might impair the member’s objectivity and professional judgement (e.g., as with close friends or relatives) must be avoided and/or the counseling relationship terminated through referral to another competent professional.

B.14 The member will avoid any type of sexual intimacies with clients. Sexual relationships with clients are unethical.

H.12 Members must ensure that forms of learning focusing on self-understanding or growth are voluntary, or if required as part of the educational program, are made known to prospective students prior to entering the program. When the educational program
offers a growth experience with an emphasis on self-disclosure or
other relatively intimate or personal involvement, the member must
have no administrative, supervisory, or evaluating authority
regarding the participant.

H.13 The member will at all times provide students with clear and
equally acceptable alternatives for self-understanding or growth
experiences. The member will assure students that they have the
right to accept these alternatives without prejudice or penalty.
APPENDIX M

HUMAN SUBJECTS REVIEW COMMITTEE

STUDY APPROVAL FORM
Research Involving Human Subjects

ACTION OF THE REVIEW COMMITTEE

With regard to the employment of human subjects in the proposed research protocol:

93B0117  THE RELATIONSHIP OF DUAL RELATIONSHIP ETHICALITY TO THERAPEUTIC STRESS, TOLERANCE FOR AMBIGUITV, PERSONAL BOUNDARY TENDENCIES, AND GENDER: A NATIONAL SURVEY, James V. Wigtil, Jeanete Belz, Educational Services and Research

THE BEHAVIORAL AND SOCIAL SCIENCES REVIEW COMMITTEE HAS TAKEN THE FOLLOWING ACTION:

___ APPROVED  ___ DISAPPROVED

X  APPROVED WITH CONDITIONS*  X  WAIVER OF WRITTEN CONSENT GRANTED

* Conditions stated by the Committee have been met by the Investigator and, therefore, the protocol is APPROVED.

It is the responsibility of the principal investigator to retain a copy of each signed consent form for at least four (4) years beyond the termination of the subject’s participation in the proposed activity. Should the principal investigator leave the University, signed consent forms are to be transferred to the Human Subjects Review Committee for the required retention period. This application has been approved for the period of one year. You are reminded that you must promptly report any problems to the Review Committee, and that no procedural changes may be made without prior review and approval. You are also reminded that the identity of the research participants must be kept confidential.

Date:  April 19, 1993

HS-625B (Rev. 8/96)

Signed:  
(Chairperson)