Dual relationships: A national study of addiction counselors' beliefs and behaviors.

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DUAL RELATIONSHIPS: A NATIONAL STUDY OF ADDICTION COUNSELORS' BELIEFS AND BEHAVIORS

by

Jacquelyn St. Germaine

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DEDICATION

This work is dedicated to my friends and family for their endless support, patience, and understanding. I especially wish to thank the following friends and colleagues: Dena Baumgartner, Yvette Dawson-Rybolt, Madeleine Lapointe, Beverly Lyle, Sharon Nielsen, and Ronald Terrazas. Most importantly, this dissertation is dedicated to my son, James Rosenberger.

TABLE OF CONTENTS

TABLE OF CONTENTS--Continued

LIST OF TABLES

ABSTRACT

The study of ethical beliefs and behaviors of mental health professionals has become important of late. Of particular relevance is the "dual relationship", a second relationship that occurs between counselor and client. Addiction counselors, many of whom are recovering alcoholics/addicts, are often placed in situations, such as 12-step meetings and recovery groups, that could result in dual relationships. A national survey of 2000 Certified Addiction Counselors was conducted to determine their ethical beliefs and practices in the area of dual relationships. The results were compared to the Borys and Pope (1989) national study of psychologists, psychiatrists, and social workers. The majority of counselors rated 11 behaviors as "never ethical" and had never engaged in 19 of the 20 behaviors, a more conservative report than the subjects of the Borys and Pope (1989) study. No significant differences were found in reported practice of 13 behaviors between the two studies.

Addiction counselors reported higher rates of practice on four items and lower rates of practice on three items than the Borys and Pope subjects. Respondents report the same rate of engaging in sexual dual relationships with current clients as the other group (.5%). While over half

of counselors were recovering alcoholics/addicts, this variable had no effect on ethical beliefs or behaviors.

CHAPTER 1

INTRODUCTION

Ethical issues are not always clear in situations regarding treatment of clients and practice management. Complex ethical dilemmas arise and must be dealt with in a manner that places a high priority on the welfare of the client. Therefore, the study of ethical beliefs and behaviors of mental health professionals is an important and timely one.

Of particular significance is the area of "dual relationships". A dual relationship exists when a therapist is in "another, significantly different relationship with one of his or her patients" (Pope, 1991, p. 21).

The most common forms of dual relationships are business, financial, social, and occasionally, sexual. A therapist who counsels a friend is in a dual relationship, as is one who is a business associate of a client, or who hires a client to help out in the office, or who has sex with a client. Dual relationships can occur concurrently or sequentially, and there is a great deal of controversy over the question of when a client stops being a client. Whether the dual relationship is sexual or nonsexual, the therapist is more often male and the client is more often

female (Holroyd & Brodsky, 1977; Pope, Levenson, & Schover, 1979; Pope, 1990).

Dual relationships are an emerging ethical issue, in part because of recent research showing that these relationships jeopardize therapist judgment, negatively affect client welfare (Borys & Pope, 1989; Pope, 1988), and often are the reason for malpractice suits against therapists Corey, Corey & Callanan, 1993), including cases where the therapeutic relationship ended prior to the initiation of another type of relationship (Vasquez, 1991)

Statement of the Problem

All disciplines of mental health professionals have, as part of their ethical codes, a prohibition against sexual relationships with patients (American Counselors Association, formerly, American Association of Counseling and Development, 1988; American Psychological Association, 1992; American Association of Marriage and Family Therapists, 1991; National Association of Social Workers, 1990; National Association of Alcohol and Drug Abuse Counselors, 1991). Additionally, many have guidelines suggesting noninvolvement in other kinds of relationships between therapist and client which could result in exploitation of the client or the impaired judgment of the therapist, including business and social relationships, and

providing counseling to employees, supervisees, and students.

In spite of these ethical principles, one of the most common complaints in malpractice suits and to licensing and certifying boards is in the area of dual relationships (Pope, 1989a; Pope, 1989c; St. Germaine, 1993). It has become such a problem that some malpractice insurers have placed a cap on what they will pay in these suits.

The most important reason for studying and being concerned about dual relationships is the potential for harm to the client. While little is known about the prevalence of nonsexual dual relationships and whether they are harmful to clients, there is a growing body of research in the literature reporting the incidence of sexual dual relationships and subsequent harm to clients (Bouhoutsos, Holroyd, Lerman, Forer & Greenberg, 1983; Committee on Women in Psychology, 1989; Pope, 1988; Pope, 1990a; Pope, 1990b; Sonne & Pope, 1991).

Surveys have been employed utilizing national samples of psychologists (Holroyd & Brodsky, 1977; Pope, Levenson & Schover, 1979; Pope, Keith-Spiegel & Tabachnick, 1986; Pope, Tabachnick & Keith-Spiegel, 1987); psychiatrists (Gartrell, Herman, Olarte, Feldstein & Localio, 1986); social workers (Gechtman & Bouhoutsos, 1985); and all three groups concurrently (Borys & Pope, 1989).

No study, national or otherwise, has focused on addiction counselors and dual relationships. Sexual and social contacts with clients in the addiction field may be more complicated than in other mental health fields due to the nature of addiction itself (Bissell & Royce, 1987). Many professionals in this field are, themselves, recovering from some form of addiction and maintain their recovery in large self-help groups such as Alcoholics Anonymous (A. A.) where it is very common to encounter current and former clients.

Parental addiction and early childhood trauma may play a part in choosing to become a mental health professional (Elliott & Guy, 1993) due to familiarity with a "caretaker" role that those raised in other family situations might not be so willing to take on (Guy, 1987). Racusin, Abramowitz, and Winter (1981) found that 50% of clinicians in their study reported having grown up in families where alcoholism and/or child abuse had occurred. In the same study, 50% of respondents reported having taken the "parenting" role in the family. The prevalence of alcohol and substance use among therapists has been estimated to be as high as 100% greater than the rate reported for the general population (Deutsch, 1985). In a recent study of mental health professionals, Elliott and Guy (1993) found that they report a significantly higher rate of childhood trauma and

parental alcoholism than do other professionals. What part these factors play in beliefs about and the practices of dual relationship behaviors is not known. Addiction counselors may be the only group of mental health professionals who began their careers as helpers because of their own experience with addiction and the recovery process (Doyle Pita, 1992).

A. A. and similar self-help groups provide a structure for daily living that includes "sponsorship" (helping newcomers learn and practice the tenets of the group), and social activities which support non-drinking, non-drugging lifestyles. In this arena, professionals and clients, find themselves as equals, there for the same simple purpose of helping each other and themselves achieve and maintain lifelong freedom from the use of alcohol and drugs. The extratherapeutic contact with clients may be particularly dramatic in rural areas and on Native American reservations where it is common for professionals to also serve as mentors, friends, spiritual advisors, and relatives.

Significance of the Problem

Certainly most dual relationships are nonsexual in nature, however the vast majority of the research has been on the prevalence of sexual dual relationships and their effects.

Durre (1980) found among female patients who had been intimate with their therapists "many instances of suicide attempts, severe depressions (some lasting months), mental hospitalizations, shock treatment, and separations or divorces from husbands" (p. 242). She also found loss of employment, crying spells, anger, and anxiety were common.

Pope (1988) has claimed that sexual intimacies between therapist and client are "severely damaging" (p. 222). He has identified a range of symptoms that shares many similarities with post-traumatic stress disorder, calling this phenomenon the "Therapist-Patient Sex Syndrome". This syndrome, according to Pope (1988), involves ambivalence, guilt, emptiness and isolation, sexual confusion, impaired ability to trust, identity and boundary confusion, being emotional labile, unexpressed rage, increased suicidal risk, and cognitive dysfunction. Sonne and Pope (1991) suggest that therapist-patient sexual intimacy shares many dynamics with rape and child sex abuse; i. e., characteristics of perpetrators, use of power, lack of consent, and consequences.

Several state legislatures (Colorado, Minnesota, and Wisconsin) have become so concerned that they have passed laws which make therapist-client sexual activity a felony (Herlihy & Corey, 1992). Florida's Board of Psychological Examiner's has included former clients, as well, in their

prohibition, saying that the counselor-client relationship never ends (Corey et al., 1993).

We do not yet know whether and to what extent nonsexual dual relationships cause harm to clients, however, there is enough concern that as ethical codes are revised, the trend has been toward including nonsexual dual relationships that may result in harm and exploitation of clients (Herlihy & Corey, 1992). The ethical code of the American Association for Marriage and Family Therapy (AAMFT, 1988) states "Marriage and family therapists, therefore, make every effort to avoid dual relationships with clients that could impair their professional judgment or increase the risk of exploitation. Examples of such dual relationships include, but are not limited to, business or close personal relationships with clients." (p. 1). Additionally, a caution is expressed regarding roles of supervisors and employers when relating to students. "Examples of such dual relationships include, but are not limited to, provision of therapy to students, employees, or supervisees, and business or close personal relationships with students, employees, or supervisees. Sexual intimacy with students or supervisees is prohibited." (p. 4). Complaints to certification and licensing boards in California have increased (Herlihy & Corey, 1992).

At the same time, not all professionals agree that nonsexual dual relationships are harmful (Herlihy & Corey, 1992; Ryder & Hepworth, 1990); unethical (Corey et al., 1993); easily recognized (Pope & Vasquez, 1991); or can be avoided (Keith-Spiegel & Koocher, 1985; Kitchener, 1988; Kitchener & Harding, 1990).

Only one national study has focused on the area of nonsexual dual relationships (Borys & Pope, 1989). This study compared beliefs and actual behaviors of psychologists, psychiatrists, and social workers using a large sample (N = 4800). No large studies have looked at whether nonsexual dual relationships between therapists and their clients have resulted in client harm. To date, no large studies have compared client experience with counselor report. No study in this area has been conducted with addiction counselors, many of whom have more opportunities for nonsexual and sexual dual relationships than other mental health professionals.

Purpose of this Study

This study had five purposes. The first was to identify ethical beliefs of Certified Addiction Counselors about specific dual relationship behaviors. The second purpose was to determine the frequency of dual relationship behaviors, both sexual and nonsexual, between Certified Addiction Counselors and their clients. Third, this study

was designed to replicate a prior national study of psychologists, psychiatrists, and social workers (Borys & Pope, 1989) and to compare results with the previous findings to examine the differences in responses from addiction counselors and the other combined groups. The fourth purpose was to find out if there are significant differences in beliefs and behaviors based on whether the counselor is a recovering alcoholic/addict, whether the counselor is an adult child of an alcoholic/addict, or attended an ethics class. The fifth purpose was to examine the perceived helpfulness or harmfulness to the client from outside contact with the therapist. This is the first study of its kind using a large national sample of addiction counselors. It is the first study addressing the subject of dual relationships in the addiction field.

Definition of Terms

The following terms are used interchangeably in this dissertation. They are: Counselor/therapist, client/patient, counseling/therapy, and 12-step groups/recovery groups/self-help groups. These are not meant to confuse the reader. When reporting results of other studies, the same terms that are used in each study are applied here.

CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

Ethics is defined as "a system of moral principles" which is related to "human conduct, with respect to the rightness and wrongness of certain actions and to the goodness and badness of the motives and ends of such actions" (Webster's Encyclopedic Unabridged Dictionary of the English Language, 1989, p. 489). All mental health professional associations have formed codes of ethics to provide strong guidelines for those practicing psychotherapy and counseling. Ethics is important to therapy because the therapist is in the position of evaluating the client's life, decision making, pathology, and conscience (Woody, 1990). In fact, ethical behavior is thought to be one of the most important responsibilities of a therapist (Vasquez, 1991).

Codes of ethics supply broad guidelines, and in some cases, clear sanctions, however are not sufficiently explicit to cover every situation (Corey et al., 1993). Ethical codes are binding on their members and it is incumbent on practitioners to stay abreast of codes, laws, and community standards related to their conduct with clients.

Ethical principles are based on the Hippocratic Oath and contain the following ideals: 1. Do no harm; 2. Practice only with competence; 3. Do not exploit; 4. Treat people with respect; and, 5. Protect confidentiality (Pope et al., 1987). Redlich and Pope (1980) have suggested adding two other principles to help coordinate ethical guidelines with other standards of practice. They are: 1. Act, except in rare circumstances, with informed consent; and, 2. Practice, as much as possible within a framework of social justice and equity.

While the idea of an ethical code for healing professionals is not new, written ethical codes for mental health professionals are relatively recent. The American Psychological Association (APA) was founded in 1892, however, was not able to create an ethics committee for ensuring standards until the late 1930's (Pope, 1990a). The committee informally handled complaints until 1947 when it recommended that APA develop a formal code (Pope & Vetter, 1992). After much data gathering and nine drafts, the 1959 revision was adopted (Pope & Vetter, 1992). The code was unique in that it was based on an empirical study of actual ethical dilemmas encountered by psychologists in practice.

In a recent study of ethical dilemmas faced by psychologists, Pope and Vetter (1992) found that the second

most frequently mentioned dilemma, after confidentiality issues, involved blurred, dual, or conflictual relationships. As mentioned in a previous section of this study, all mental health professional ethical codes proscribe sexual dual relationships although the APA did not explicitly prohibit sexual relationships with clients until the late 1970's (APA, 1977). Most codes also strongly urge an avoidance of nonsexual dual relationships, such as business, social, financial, or personal, which could impair the professional's judgment and be potentially exploitative of the client.

Pope (1991) has cited six problems with dual relationships which include distortion of the professional nature of the therapeutic relationship; creation of a conflict of interest; the potential for being called into court regarding the client's diagnosis and treatment; the power imbalance inherent in the therapist-client relationship which prohibits the client from entering into a business, social or sexual relationship as an equal; placing the therapist's needs before the patient's; and interfering with cognitive processes needed to maintain the benefits of therapy after termination.

Sexual Dual Relationships

The Hippocratic oath long ago established the sanction against sexual intimacies between therapist/healer and client:

> In every house where I come, I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women and men.
>
> (Dorland's Medical Dictionary, 1974, p. 175).

Freud (1915/1963) concluded that sexual intimacies with a client defeat the cure. However, ethical codes did not explicitly prohibit sexual contact until 1973 (Holroyd & Brodsky, 1980). As late as 1977, Davidson (1977) called it the "problem with no name" and many authors and presenters found it almost impossible to get published in journals or have their material accepted at conferences (Pope & Bouhoutsos, 1986). In trying to get his paper on the topic accepted, Dahlberg (1971) was told that "it was too controversial" (p. 34).

In the first national study of mental health professionals and dual relationships, Holroyd and Brodsky (1977), found 1.9% of female psychologists and 10.9% of male psychologists had erotic contact with clients, that 80% had been involved with more than one client, and that

male therapists were most often involved with female clients. Other national surveys reported similar results (Borys & Pope, 1989; Gartrell et al., 1986; Gechtman & Bouhoutsos, 1985; Pope et al., 1986; Pope, Levenson & Schover, 1979; Pope et al., 1987) with the average incidence rates of these studies being 1.7% of female therapists and 7% of male therapists. It appears that, over time, the incidence of therapist-client sexual involvement has gone down somewhat (Borys & Pope, 1989; Pope, 1990b; Stake & Oliver, 1991) withthe most recent rates being 0.9% - 3.6% for male therapists and 0.2% - 0.5% for female therapists. This may reflect actual changes in behavior or a reluctance to report, given legal ramifications, including that it is a felony in some states (Pope et al., 1987).

On the other hand, it is possible that the incidence is under-reported. Only 8% of psychiatrists who know about therapist sexual misconduct actually report it (Gartrell et al., 1987) and only 4% of abused clients file complaints (Pope, 1989).

Among marriage and family therapists, the incidence may be significantly higher than that for psychologists, psychiatrists, and social workers. Boatwright (1989, cited in Sonne & Pope, 1991) reported that 13% of marriage counselors reported having had sex with a client.

It is the most violated ethical standard among psychologists (APA, 1987), the second most frequently claimed type of violation against licensed professional counselors (Herlihy, Healy, Cook & Hudson, 1987), and it is one of the major causes of malpractice suits (Herlihy & Corey, 1992). Few defense arguments succeed in court including claims that the client consented or that the sexual relationship began after the therapeutic relationship had ended (Austin, Moline & Williams, 1990).

In a majority of cases, the therapist is male and the client is female (Pope, 1990b). The therapist is older (by about 11 years) and in some cases the client has been a child, either male and female, aged 3 to 17 (Bajt & Pope, 1989). Therapists who have sexual relationships with clients are likely to do so again (Bates & Brodsky, 1989), with a recidivism rate perhaps as high as 80% (Holroyd & Brodsky, 1977).

The most important problem with dual relationships is the harm incurred by the client. Denial has played a major role in therapists not recognizing the damage done to clients, although most are aware that they are violating ethical, legal, and therapeutic standards (Folman, 1991; Pope, 1988; Pope, Tabachnick & Keith-Spiegel, 1988). In early writings on this topic, it was proposed that there was a lack of harm associated with therapist-client sexual

contact (McCartney, 1966; Romeo, 1978; Shepard, 1971), however, more recent research shows the negative and even destructive consequences of this behavior (Durre, 1980).

Bouhoutsos et al. (1983) found that 90% of clients who were involved in sexual relationships with their therapists were harmed, as reported by subsequent therapists. Harmful effects included inability to trust or seek further help, depressions, hospitalizations, and suicidal behavior. Holroyd and Bouhoutsos (1985) later reported that a greater percentage of clients may have been harmed but were not reported due to respondent bias in the Bouhoutsos et al. (1983) study. In a replication of this study, using a national sample, Pope and Vetter (1991) also found that 90% of clients were harmed by sexual contact with their therapist.

Pope (1988) concluded that a distinct syndrome, which he termed the Therapist-Patient Sex Syndrome, was developed by clients as a result. Cognitive dysfunction, identity and boundary disturbance, ambivalence, lability of mood, inability to trust, sexual confusion, suppressed rage, and feelings of guilt, and emptiness characterize this syndrome. The syndrome appears to share much in common with post traumatic stress disorder, rape response syndrome, reaction to incest, and battering (Pope et al., 1986). Masters and Johnson (1975) found sexual relations

between therapist and client to be traumatic and described it as being tantamount to rape.

Nonsexual Dual Relationships

Most professional mental health organizations have as part of their ethical codes a prohibition against nonsexual as well as sexual dual relationships (Kitchener, 1988). The American Association for Counseling and Development (AACD), now known as the American Counselors Association (ACA), Code of Ethics (1988) states "Dual relationships with clients that might impair the member's objectivity and professional judgment (e.g., as with close friends or relatives) must be avoided and/or the counseling relationship terminated through referral to another competent professional."

The APA Code of Ethics (1992), referring to nonprofessional or social contacts with patients, clients, students, supervisees, and research participants, states

> A psychologist refrains from entering into or promising another personal, scientific, professional, financial, or other relationship with such persons if it appears likely that such a relationship reasonably might impair the psychologist's objectivity or otherwise interfere with the psychologist's effectively performing

his or her functions as a psychologist, or might harm or exploit the other party (p. 1601).

The warning to avoid dual relationships is worded very similarly, and stated previously in this paper, in the AAMFT Code of Ethics (1991) with business and close personal relationships cited as examples.

These warnings are less clear than the warnings against sexual dual relationships, and may represent the ambivalence of practicing therapists, however, many researchers have expressed concern, pointing out potential ethical traps (Corey et al., 1993; Herlihy & Corey, 1992; Kitchener, 1988). Keith-Spiegel and Koocher (1985) discuss relationships that are potentially problematic including accepting expensive gifts from students or clients, bartering for services, social relationships with clients or students, and teaching friends or relatives. These relationships place the therapist in a conflict of interest situation which could compromise effectiveness.

State licensing boards have become more interested in these types of relationships and in 1990 the California licensing board distributed a pamphlet to licensed therapists that certain dual role behaviors, such as bartering goods or services for therapy and employing a client constituted "inappropriate behavior" (California Department of Consumer Affairs, p. 3).

Kitchener (1988) gives three guidelines for determining which dual relationships have a high probability of being problematic. First, she suggests that the potential for misunderstanding and harm is positively correlated with the increased incompatibility of expectations between therapist roles. Second, the potential for divided loyalties and loss of therapist objectivity increases as the requirements of different roles diverge. Third, with increased power and prestige between the therapist's and the client's roles, the potential for client exploitation and the inability for the client to be objective also increases. She adds that a large power differential which generally exists between therapist and client is a factor that would, if present, suggest that a dual relationship has a strong potential for exploitation and harm.

Kitchener (1988) is quick to note that not all dual relationships are avoidable or harmful. Where there is a small power differential, conflicts of interest are small or nonexistent, and role expectations are compatible, there is little chance of harm.

Ryder and Hepworth (1990) challenge the idea that all nonsexual dual relationships are unethical. They contend that aspects of nonsexual dual relationships are "ubiquitous", that they are "virtually impossible to

eliminate", and that absolute elimination of them would be a "bad idea" (p. 129). For them, dual relationships are not, in and of themselves, the problem. The problem is when there are differences in status and power. In response to Ryder and Hepworth (1990), Bernard (1991) proposes that the purpose of the ethical code regarding nonsexual dual relationships is to avoid those that are harmful, not necessarily all.

Borys and Pope (1989) conducted the only national survey of mental health professionals examining nonsexual dual relationships and beliefs regarding the degree to which each behavior was considered unethical. This study compared large samples (N = 1600 each) of social workers, psychologists, and psychiatrists. They found that there was no significant difference in behaviors or ethical beliefs between professional groups regarding sexual dual relationships, nonsexual dual relationships, social involvements, or financial involvements with patients. As with sexual relationships, male therapists tend to become involved in nonsexual dual relationships more with female clients than with male clients. Males also tended to rate nonsexual dual relationship behaviors, social and financial involvements as more ethical than did females. For a review of types of nonsexual dual relationships, see St. Germaine (1993).

Former Clients

Until recently, only one mental health professional code of ethics explicitly forbade sexual relationships with clients after termination of therapy. The AAMFT Code of Ethics (1991) states "Sexual intimacy with clients is prohibited. Sexual intimacy with former clients for two years following the termination of therapy is prohibited".

It was proposed to the APA that the same prohibition be made explicit ("Ethical Principles Revised," 1990) and they recently included a similar statement in their revised code (APA, 1992). No code prohibits sexual relationships with former clients beyond two years after termination.

Sell, Gottlieb, and Schoenfeld (1986) found few certification and licensing boards have formal guidelines regarding this issue, however, of those complaints heard, 70% were found to be in violation of ethical standards.

Divergent opinions are common among boards and professionals about what time interval, if any, should be used and what consequences would apply (Akamatsu, 1988). In a study of psychologists, Akamatsu (1988) found that 11% (14.2% male and 4.7% female) of the respondents had been sexually intimate with former clients. Only 68.6% rated sexual relationships with former clients as "very unethical" or "somewhat unethical" while the rest rated them as "neither ethical nor unethical" (22.9%),

"somewhat ethical" (3.7%), and "very ethical" (4.7%), indicating how ambivalent the profession is toward this issue.

Surveying psychiatrists, Herman, Gartrell, Olarte, Feldstein, & Localio (1987) reported 29.6% of their sample felt that sexual contact after termination could sometimes be appropriate. Coleman (1988) argued that sexual relationships with former clients is not a problem and a prohibition is unnecessary if the client is not harmed. However, roughly half of psychologists believed this behavior to be unethical in a study by Pope et al., (1987).

Regarding nonsexual dual relationships with former clients, Akamatsu (1988) found that 87.5% believed some types were ethical, such as informal socializing and nonsexual close friendships. Only 6.4% of psychologists surveyed by Pope et al. (1987) believed that becoming friends with former clients was unethical.

Addiction Counselors

Prevalence of Addiction

Alcoholism and drug abuse are major problems in this country, affecting millions of Americans, one which does not appear to be going away. In a 1988 national study sponsored by the National Institute for Alcoholism and Alcohol Abuse (NIAAA) (N = 43,809, ages 18 and older), 6% were found have alcohol problems (Grant, 1992). This

represents 10,624,000 adults. Some 2 million Americans are addicted to cocaine and another 700,000 to heroin (Falco, 1992). Chemical dependency often occurs simultaneously with other psychiatric disorders and may not always be identified. Barral and Standage (1992) found that 16% of patients on a psychiatric unit also had a chemical dependency problem.

Substance use by adolescents and children also is a critical problem contributing to delinquency, school problems, cognitive and neurological deficits, low self-esteem, loss of hope about the future, suicide, and exposure to AIDS.

The use of drugs by youth is so widespread that it is now the statistical norm for adolescents to engage in some degree of illegal drug taking (Grob & Dobkin de Rios, 1992). Drug use in the last 20 years has spread downward to include younger adolescents and even preadolescents. An important aspect of substance abuse in children and adolescents is that of multiple drug use, now the rule and not the exception (Bailey, 1989).

Nearly 60% of all high school seniors have experimented with illicit drugs and 93% have tried alcohol (Johnson et al., 1990). The National Council on Alcoholism estimates that at least 3 million teenagers are problem drinkers (cited in Johnson et al., 1990).

The need for counseling and rehabilitative services for the chemically dependent will not drop in the 1990's and for special subgroups (i. e., women, children, adolescents, minorities, elderly) may expand (Westermeyer, 1992). Obviously, substance abuse problems are not going away anytime soon and professionals working with this population need to be thoroughly trained and have a clear understanding of the ethical issues involved.

Boundaries and Dual Relationships

Boundary functioning is significantly altered by substance abuse and boundary violations are common within alcoholic and drug-addicted families (Coleman & Colgan, 1986). Preli, Protinsky, and Cross (1990) found when comparing alcoholic and nonalcoholic families that alcoholic families showed disturbed interactional boundaries and that nonalcoholic families do not show the same level of structural dysfunction.

Boundary violations are seen clinically in higher rates of both childhood physical and/or sexual abuse and current family violence than in other populations (Evans & Schaefer, 1987). Regardless of the type or severity of the violation, the result for the victim is the experience of guilt and shame with increased intensity when the violator is someone in an authoritative role such as counselor (Nielsen, 1987).

The therapeutic relationship occurs within a secure set of boundaries on which both client and therapist can rely (Pope, 1991) and is particularly relevant with chemically dependent clients and their families because it influences the restructuring of boundaries (Nielsen, 1987). Preli et al. (1990) found that recovering alcoholic families had fewer boundary distortions than practicing alcoholic families, indicating that boundaries do get restructured in recovery and treatment.

Dual relationships violate boundaries and compromise the therapeutic relationship (Pope, 1991). Folman (1991) makes the point that the most significant precipitant to a sexual dual relationship is this erosion of boundaries.

Nielsen (1987) has proposed that substance abuse counselors may be particularly vulnerable to professional boundary violations as they are often recovering substance abusers and/or products of chemically dependent families. These counselors may, themselves, have poor boundary functioning which could lead to boundary violations. Unresolved personal issues such as a history of victimization, personal crisis, lack of self-care, and loneliness are all cited as reasons therapists exploit clients to meet their needs (Coleman & Schaefer, 1986).

Chemically dependent clients are often vulnerable to exploitation. In the beginning of treatment, the client

with their former clients on a regular basis, often for years, unlike other professionals who may never encounter a former client in a social situation.

5. Some of these recovering clients may become future financial donors to programs counselors work in and may even become colleagues.

Before the concept of dual relationship became well-known, recovering professionals were often called "two-hatters" in A. A. because they wear both "hats" of counselor and recovering person. A. A. even has a pamphlet with suggestions for the recovering counselor working in the field (For A. A. Members Employed in the Alcoholism Field) to help them negotiate the potential problems of being in both roles.

Ethical Standards for Addiction Counselors

The National Association of Alcoholism and Drug Abuse Counselors (NAADAC) Ethical Standards of Alcoholism and Drug Abuse Counselors (1991) has two principles which speak to the issue of dual relationships. Principle 9c. addresses nonsexual dual relationships and states "The alcoholism and drug abuse counselor must not enter into a professional relationship with members of one's own family, intimate friends or close associates, or others whose welfare might be jeopardized by such a dual relationship."

Regarding sexual dual relationships, the code states "The alcoholism and drug abuse counselor must not engage in any type of sexual activity with a client". (Principle 9d.) Relationships with former clients are not addressed. There are no guidelines for recovering counselors who are in dual roles in their self-help groups or for those who find themselves in collegial situations with former clients.

Ethical Complaints Against Addiction Counselors

In a recent study of addiction counselor certification boards, St. Germaine (1993) found that the most common complaint against addiction counselors was for having had a sexual relationship with a current client (16.40%). Sexual relationship with a former client was cited in 5.65% of the complaints, and all dual relationships combined amounted to 28.49% of ethical complaints against addiction counselors. These figures are slightly higher than the findings of a recent study of licensed professional counselors (Neukrug, Healy & Herlihy, 1992) which reported 20% of ethical complaints were for having had a sexual relationship with a current or former client. In a five-year study of ethical complaints against psychologists, combined dual relationships represented 23% of ethical violations (Ethics Committee of the American Psychological Association, 1988b).

Summary

Much has been documented about professional beliefs and dual relationship behaviors among psychologists, psychiatrists, and social workers, however no study has yet examined these issues with addiction counselors.

There are many important questions to explore in regard to addiction counselors and the matter of dual relationships. Boundary inadequacies that characterize people affected by chemical dependency are brought into the therapeutic relationship by both client and therapist. Because of the nature of addiction and recovery, client and therapist may have regular ongoing exposure to each other in self-help settings where they are considered equals. Bissell and Royce (1987) summarize it by saying "Today's patient in treatment becomes tomorrow's peer at A.A." (p. 35). Counselor and client may someday find themselves working side by side in their place of employment. What harm, if any, that comes to therapist and client as a consequence of these contacts is unknown. The prevalence of specific dual relationship behaviors and counselor beliefs about them in the addiction field is also unknown, although it seems likely that these behaviors occur at least as commonly, if not more so, as with other mental health professionals.

CHAPTER 3

METHODOLOGY

The purposes of this research were addressed through the utilization of the following methodology. This chapter includes a description of the study sample, instrumentation, survey process, and statistical analyses of the data.

Sample

The sample consisted of 1,000 male and 1,000 female United States Certified Addiction Counselors who have met the certification requirements of the International Certification Reciprocity Consortium (ICRC) which sets standards for the addiction field, to constitute a total sample of 2,000. Requirements for this certification combine a minimum of three years of experience as an addiction counselor along with at least 270 clock hours of education, 180 hours of which must be alcohol and drug abuse education, and documented supervised training in each of twelve core counseling functions. A year's experience is waived if the individual holds a college or advanced degree. Recently certified counselors have taken a standardized written and oral test. Counselors who were certified prior to 1991 may have been grandfathered in after having met similar requirements at the state level. The population targeted by this study were currently

practicing or had been within the last five years, and worked with adult clients. This sample was selected randomly out of a possible population of approximately 22,000 addiction counselors. Mailing labels with counselor names and addresses were purchased from the ICRC.

Instruments

Two forms of the Therapeutic Practices Survey (Borys & Pope, 1989) were used and permission was granted by the authors (personal communication, D. Borys, November 16, 1992). The form was developed by Debra Borys in 1989 for her Ph.D. dissertation research and is copyrighted. The purpose of its development was to determine the ethical beliefs and behaviors of psychologists, psychiatrists, and social workers in relation to dual therapist roles. It was patterned after the survey developed by Pope et al. (1987) which asked psychologists to rate how ethical they believed each of 83 behaviors to be and to report to what extent they had engaged in each behavior.

Each form contained a roster of behaviors that represent incidental involvements and dual relationship behaviors that might occur between a counselor and client. The forms used in this study were identical to those used in the Borys and Pope study.

Most items involved types of dual relationships, including financial and social. Examples of these items

are "inviting clients to a personal party or social event" and "accepting a service or product as payment for therapy". Some involved one-time events that don't technically qualify as dual relationships, however involve boundary violations on the part of the client which may put the counselor in a conflict-of-interest situation, for example, "accepting a gift worth under $10 from a client".

As in the aforementioned study, two forms were utilized. On the "ethics" form respondents indicated their beliefs regarding to what degree they considered each behavior to be ethical using a scale (5 = always ethical and 1 = never ethical). Demographic information including gender, age, marital status, advanced training, practice status, experience, theoretical orientation, client population, practice setting, social isolation, residence, and outside encounters with clients was provided for in a second section.

Four new demographic items were added. These were "how helpful or harmful to your clients have your encounters (intentional or unintentional) outside of therapy sessions been?", "are you a recovering alcoholic or addict?", "are you an adult child of an alcoholic or addict?", and "have you ever attended an ethics class?"

Respondents indicated the proportion of clients with whom they had engaged in each of the listed behaviors on a

frequency scale (5 = all clients and 1 = no clients) on the "practices" form of the survey. The same demographic questions as those on the "ethics" form were used with the "practices" form.

Procedure

Each of the 1,000 males and 1,000 females was randomly assigned to receive either the "ethics" form or the "practices" form. Each of the 2,000 individuals was sent a one-page cover letter with a two-week deadline for return, a one-page survey form (front and back), and a stamped, addressed envelope for returning the form. Because of the sensitive nature of the some of the questions, complete anonymity was assured. Respondents were encouraged to send a self-addressed stamped envelope if they wanted to receive survey results. At six weeks, it was assumed that all responses had been received, as only a handful had come in during the previous two weeks.

Statistical Analyses

Data gathered in this study were entered into an Extensible VAX Editor (EVE) file through the Center for Computing and Information Technology (CCIT) in the University of Arizona's main frame computer system. The data were then processed by the Statistical Package for Social Research (SPSS) software to produce the desired analyses.

To make this study as close a replication as possible of the Borys and Pope (1989) study, all of the statistical methods used in their study were utilized here. They included descriptive statistics, frequencies, one-way analysis of variance (ANOVA), factor analysis, Harris-Kaiser oblique rotation, post hoc Scheffe, and planned contrasts.

Data sets were combined and groups were tested for similarities using one-way analysis of variance. Additional analyses were completed to allow for the comparison of these results with Borys and Pope using Pearson chi-square test of association.

CHAPTER 4

RESULTS

Survey forms were returned by 858 of the 2000 subjects. One hundred seventy two were undeliverable, making an overall response rate of 47% for those who received questionnaires. Of the 858 surveys returned, 31 were returned by counselors who were not currently or recently practicing or who had only children as clients, leaving a total of 827 responses that were used for analysis. Of those, 431 formed the "ethics" group and 396 formed the "practices" group.

Description of Respondents

The following is a description of respondents on 15 clinician characteristic variables. For comparison sake, differences from the Borys and Pope sample are also noted.

Gender

The final sample was 56.5% female (n = 468), and 43.3% male, (n = 359). Borys and Pope reported 52.4% female and 47.4% male.

Age

The mean age of respondents was 47.33 years; the range was 26 to 75 years. For the purpose of statistical analysis, respondents were divided into five age groups (21-34, 35-44, 45-54, 55-64, and 65 and over). The average

age resembles the Borys and Pope study (48.18), however the range was 23 to 91 years.

Marital Status

Married respondents amounted to 61.8% (n = 511) of the respondents; 7.4% (n = 60) were cohabiting with a partner; 19.5% (n = 162) were separated or divorced; 10.3% (n = 85) were single; and 1% (n = 9) were widowed. In the Borys and Pope study, 70% were married; 13% separated or divorced; 9.3% single; 4.7% were cohabiting; and 1.3% were widowed.

Advanced Training

One fourth of counselors reported being currently involved in an advanced degree program (24.5%; n = 203). While this question was asked in the other study, it was not reported.

Experience

The average respondent reported 12.50 years of experience providing counseling services; the range was 1 to 35 years. For statistical analyses, respondents were divided into four groups by the number of years' experience that they reported: 10 or fewer, 11-20, 21-30, and more than 30. Borys and Pope reported an average 16.37 years of experience and a range from 1 to 51 years.

Theoretical Orientation

Respondents were asked which of six theoretical orientations influenced their practice most: behavioral,

cognitive, existential, gestalt, psychodynamic, and "other" (with a request to label the "other"). In order to provide consistent analysis with the Borys and Pope (1989) study, responses in the "other" category that fell into one of the five major areas were reorganized into those categories. As in the previous study, existential, gestalt, and humanistic responses were combined into one category.

The theoretical orientation ranked as most influential was cognitive (34.8%; n = 288). Following in order were behavioral (24.4%; n = 202); humanistic (16.4%; n = 136); psychodynamic (10.4%; n = 86); other (those answers falling outside the larger categories) (3.5%; n = 29). No response was chosen 8.7% of the time (n = 72).

The Borys and Pope therapists ranked their primary theoretical orientations as psychodynamic (58%), cognitive (13.1%), other (8.3%), behavioral (7.9%), humanistic (6.8%), and eclectic (2.4%).

Client Population

The majority of addiction counselors reported treating more adults (92.7%; n = 728) than youths. A greater number of males (59.1%; n = 466) were treated than females (33.2%; n = 262). This differs from the other study which reported 82.2% of respondents treating a greater proportion of female to male clients (68.3%).

Practice Setting

Primary practice settings included solo private practice (13.4%; n = 111); outpatient clinics (36.8%; n = 304); group private practice (11.1%; n = 92); inpatient facilities (22%; n = 182); residential (5.7%; n = 47); and other settings such as schools, day treatment programs, community outreach programs, prisons, and employee assistance programs (10.8%; n = 89). Practice settings in the Borys and Pope sample were represented differently. Those working in solo private practice were represented by 45.7%; outpatient clients (22.7%); group private practice (14.6%); inpatient facilities (9.6%); and other settings (4.2%).

Social Isolation

A majority of counselors reported not feeling socially isolated (52.5%; n = 434); followed by those who felt mildly isolated (27.9%; n = 231); moderately isolated (14.3%; n = 118); and extremely isolated (4.5%; n = 37). This question was asked in the other study, however, not reported.

Residence

Counselors who lived and worked in two different communities represented 37.1% (n = 307). Living and working in the same urban area were 28.8% (n = 238); living and working in the same suburban area were 19.8% (n = 164);

and living and working in the same small town or rural community were 13.7% (n = 113). This was another item asked in the other study and not reported.

Outside Encounters

Most counselors encountered their clients outside of therapy, reporting sometimes (47.5%; n = 393); rarely (29.4%; n = 243); frequently (16.8%; n = 139); every day (4.6%; n = 38); and never (1.3%; n = 11). Once again, this was a demographic item asked in the previous study but not reported in the results.

Helpful/Harmful

The majority of counselors reported that their intentional and unintentional encounters with clients outside of therapy were neither helpful nor harmful to the client (68.8%; n = 569). Others reported somewhat helpful (22.4%; n = 185); very helpful (6.4%; n = 53); and somewhat harmful (1.2%; n = 10). No one chose "very harmful". This question was not asked on the other study.

Addiction Background

Addiction counselors who were recovering alcoholics or addicts represented 52.6% of respondents (n = 435). This question was not asked in the other study.

Family Background

Roughly half of addiction counselors had a parent who was either an alcoholic or an addict (52.2%; n = 432). This variable was not a part of the other study.

Ethics Training

An astonishing 92.9% (n = 768) reported they had attended an ethics class. This variable also was not in the other study.

Responses Regarding Beliefs

Table 1 presents the degree to which the 431 participants in this part of the study considered each behavior to be ethical, reported as percentage responding in each category.

Ratings of Ethical Beliefs

A majority of respondents rated 11 items as "never ethical"; selling a product to a client (80.3%; n = 346); accepting a gift worth over $50 from a client (80.3%; n = 346); providing therapy to a then-current employee (69.6%; n = 300); engaging in sexual activity with a client after termination 83%.5%; n = 360); employing a client (60.6%; n = 261); going out to eat with a client after a session (62.6%; n = 270); buying goods or services from a client (54.1%; n = 233); engaging in sexual activity with a current client (97.2%; n = 419); inviting clients to a personal party or social event (78.9%; n = 340); providing

therapy to a current student or supervisee (63.3%; n = 273); and allowing a client to enroll in one's class for a grade (50.6%; n = 218).

In only one case did fewer than 20% of participants rate an item as "never ethical"; accepting a client's invitation to a special occasion (19.0%; n = 82). Behaviors related to sexual dual relationships were the lowest rated.

On only one item did more than 10% of respondents choose "always ethical"; inviting clients to an office/clinic open house (12.8%; n = 55).

Respondents in the Borys and Pope study rated 5 behaviors as "never ethical" most of the time; sexual activity with a client before termination of therapy (98.3%); selling a product to a client (70.8%); sexual activity with a client after termination of therapy (68.4%); inviting clients to a personal party or social event (63.5%); and providing therapy to an employee (57.9%). No item was chosen more often than 10% as being "always ethical".

TABLE 1--ETHICAL BELIEFS RATINGS

Reported as percentages, n = 431

1. BEHAVIOR	NEVER ETHICAL	ETHICAL UNDER RARE CONDITIONS	ETHICAL UNDER SOME CONDITIONS	ETHICAL UNDER MOST CONDITIONS	ALWAYS ETHICAL	NOT SURE	NR*
Accepting a gift worth under $10 from a client	23.0	24.8	31.6	17.4	1.9	0.9	0.5
Accepting a client's invitation to a special occasion (e.g. his/her wedding)	19.0	32.7	27.6	16.5	2.1	1.2	0.9
Accepting a service or product as payment for therapy	40.8	24.6	21.8	6.7	2.1	3.0	0.9
Becoming friends with a client after termination	38.1	31.1	19.3	6.0	3.7	1.2	0.7
Selling a product to a client	80.3	11.1	4.9	0.7	1.6	0.9	0.5
Accepting a gift worth over $50 from a client	80.3	13.0	2.3	0.7	1.6	1.2	0.9
Providing therapy to a then-current employee	69.6	15.1	7.0	1.4	2.8	2.6	1.6
Engaging in sexual activity with a client after termination	83.5	9.7	2.3	0.2	1.9	1.9	0.5
Disclosing details of one's current personal stresses to a client	35.5	34.6	23.7	3.9	1.4	0.2	0.7
Inviting clients to an office/clinic open house	24.1	16.7	20.4	20.6	12.8	4.2	1.2
Employing a client	60.6	19.3	13.5	2.3	1.6	1.9	0.9
Going out to eat with a client after a session	62.6	21.1	12.1	1.2	1.6	0.9	0.5
Buying goods or services from a client	54.1	24.1	15.3	3.5	1.9	0.9	0.2
Engaging in sexual activity with a current client	97.2	5.0	0.0	0.0	2.1	0.0	0.2
Inviting clients to a personal party or social event	78.9	14.8	2.8	0.7	1.9	0.7	0.2
Providing individual therapy to a relative, friend or lover of an ongoing client	29.9	22.0	26.2	14.8	5.1	1.2	0.7
Providing therapy to a current student or supervisee	63.3	21.1	8.6	2.6	1.6	2.1	0.7
Allowing a client to enroll in one's class for a grade	50.6	16.7	13.9	6.0	2.8	9.5	0.5

*No response

Percentages may not total 100% due to rounding.

Factor Analysis

As Borys and Pope (1989) found, testing for possible relationships between the ethical ratings and each of their 10 counselor characteristics (such as gender, age, and marital status) separately would have inflated the probability of Type I error. Keeping consistent with the previous study, in order to minimize Type I error and to provide a meaningful statistical analysis, Harris-Kaiser oblique (rather than orthogonal) rotation was used on different numbers of factors to determine the most conceptually clear factors.

The same procedures were used as in the Borys and Pope (1989) study in order to compare results of this study with theirs. Each factor formed the basis of an index, developed by weighting participants' answers to items loaded on that factor by their factor-score loadings and then adding the weighted items, giving the same number of index scores for each participant as there were factors in the chosen factor solution. Factors were used to define the dependent variables.

The same three items were excluded from this factor analysis. The first two, "accepting a handshake offered by a client", and "feeling sexually attracted to a client", were excluded because they were originally placed in the survey as a means of comparing with previous studies'

responses to social desirability items, and did show agreement with those studies (Borys & Pope, 1989). As Borys and Pope found, over 97% of respondents answered "never ethical" to the item "engaging in sexual activity with a current client" and it was excluded because of the restricted range of responses.

Like the previous study, the remaining 17 items produced three factors, however, the make-up of the factors here differed greatly from those in the Borys and Pope study. Items making up factors and factor loadings are presented in Table 2. Titles given to the factors are similar or the same as those given to the Borys and Pope factors, however, items may be different.

Factor I (Personal/Social Involvements) consisted of items that changed the professional relationship to a more personal or social one and accounted for 39% of the variance.

Factor II (Incidental/Financial Involvements) contained items that were financial or less personal than in Factor 1 and accounted for 7.3% of the variance. Factor III (Dual Professional Roles) accounted for 6.7% of the common variance and consisted of four items, three of which place the client in a second role with the counselor, and one where the counselor is placed in a second role by providing services to a friend or relative of the client.

In this study, factors accounted for a total of 53% of the total variance. This is considered a low variance by factor analysts who recommend that 60% to 70% of the variance be accounted for by the factors.

Factors from the Borys and Pope study are presented in Table 3 for comparison. As the reader can see, the items formed very different factors.

Table 4 shows the loadings for individual items on each factor. The position of some of the items on a factor is questionable because these items have high loadings on more than one factor. These items are:

Factor I: Providing therapy to a current student or supervisee.

Factor II: Disclosing details of one's current personal stresses to a client; buying goods or services from a client.

Factor III: Employing a client, and providing individual therapy to a relative, friend, or lover of an ongoing client.

The low variance of these items present a problem in determining clearly interpretable factors. Two items, providing therapy to a current student or supervisee, and disclosing details of one's current personal stresses to a client, provide little conceptual support to the factors on which they appear and would make more sense if placed on

Factor II (Incidental/Financial Involvements), and Factor III (Dual Professional Roles), respectively.

The surveys and methods utilized in this study were the same as those employed in the Borys and Pope study and probably don't account for the low variance. The instrument itself may be weak.

TABLE 2--FACTOR INDICES FOR ETHICAL BELIEFS RATINGS

Item	Loading
Factor I: Personal/Social Involvements	
Becoming friends with a client after termination	.49
Selling a product to a client	.70
Accepting a gift worth over $50 from a client	.69
Providing therapy to a then-current employee	.62
Engaging in a sexual activity with a client after termination	.88
Going out to eat with a client after a session	.67
Inviting clients to a personal party or social event	.77
Providing therapy to a current student or supervisee	.54
Factor II: Incidental/Financial Involvements	
Accepting a gift worth under $10 from a client	.80
Accepting a client's invitation to a special occasion (e.g. his/her wedding)	.71
Accepting a service or product as payment for therapy	.58
Disclosing details of one's current personal stresses to a client	.44
Buying goods or services from a client	.38
Factor III: Dual Professional Roles	
Inviting clients to an office/clinic open house	.75
Employing a client	.49
Providing individual therapy to a relative, friend or lover of an ongoing client	.37
Allowing a client to enroll in one's class for a grade	.63

TABLE 3--FACTOR INDICES FOR ETHICAL BELIEFS RATINGS
(Borys and Pope, 1989)

Item	Loading
Factor I: Incidental Involvements	
Accepting a gift worth under $10	.83
Accepting a client's invitation to a special occasion	.43
Accepting a gift worth over $50	.68
Factor II: Social/Financial Involvements	
Accepting a service or product as payment for therapy	.61
Becoming friends with a client after termination	.68
Selling a product to a client	.66
Engaging in sexual activity with a client after termination	.68
Disclosing details of one's current personal stresses to a client	.42
Inviting clients to an office/clinic open house	.76
Employing a client	.70
Going out to eat with a client after a session	.74
Buying goods or services from a client	.63
Inviting clients for a personal party or social event	.68
Factor III: Dual Professional Roles	
Providing therapy to a then-current employee	.57
Providing individual therapy to a relative, friend, or lover of an ongoing client	.51
Allowing a client to enroll in one's class for a grade	.70
Providing therapy to a current student or supervisee	.83

TABLE 4--HARRIS-KAISER FACTOR ANALYSIS
PATTERN MATRIX

Item	Factor I	Factor II	Factor III
8	.87715	-.01807	-.17449
17	.76674	-.00376	.07424
5	.70296	.09021	.01232
6	.69352	.21566	-.10884
14	.66990	.03119	.20417
7	.61863	-.06025	.23351
19	.53708	-.08385	.40952
4	.49273	.29490	-.15245
1	-.06686	.79938	-.01323
2	.06039	.71217	.03780
3	.14335	.58158	.02975
11	.02765	.44101	.34226
15	.35585	.37545	.16401
12	-.14719	.12718	.75283
20	.22483	-.04596	.63279
13	.44748	-.05523	.48835
18	.06121	.19284	.37486

Relation Between Counselor Characteristics and Belief Factors

One-way analyses of variance (ANOVAS) were used to look for differences on each of the 15 clinician characteristics as stratified independent variables and the factors as dependent variables. Planned means contrasts followed initial ANOVAS for the statistically significant results that had been anticipated. Selected two-way factorial ANOVAS were conducted.

Alpha was set at .05 for main effects, planned contrasts, and post hoc Scheffe to minimize the possibility of a Type II error and to be consistent throughout. This differs slightly from the Borys and Pope study which used .01 for main effects and planned contrasts, and .05 for post hoc Scheffe.

Factor I: Personal/Social Involvements. Counselors' beliefs regarding Personal/Social Involvements varied significantly by sex, $F(1, 398) = 6.06$. Males believed these involvements to more ethical ($M = .1462$) than females ($M = -.1039$).

Factor II: Incidental/Financial Involvements. Respondents' beliefs regarding Incidental/Financial dual relationships varied significantly by years of experience, $F(3, 284) = 2.75$; setting, $F(5, 394) = 4.73$; and encounter, $F(4, 395) = 3.78$.

Post hoc Scheffe analyses showed that counselors with 11 through 20 years of experience (M = .1387) viewed Incidental/Financial involvements as significantly more ethical than did those with 1 through 11 years of experience (M = -.1585); and those in group private practice (M = .4178) viewed these involvements as significantly more ethical than those who worked in residential settings (M = -.4439).

Planned contrasts showed that counselors in solo or group private practice viewed such involvements as significantly more ethical than did respondents in all other settings comparisons $T(1, 394) = 4.94$.

Factor III: Dual Professional Roles. Counselors' beliefs regarding Dual Professional Roles were found to vary significantly by setting $F(5, 394) = 2.82$; residence $F(3, 395) = 2.84$; encounter $F(4, 395) = 4.16$.

Post hoc Scheffe analyses showed that counselors who encountered clients on a daily basis outside of counseling (M = .4394) viewed Dual Professional Roles as significantly more ethical than those who rarely encountered clients outside the therapeutic setting (M = -.2385).

Planned contrasts showed that those in group private practice found Dual Professional Roles to be significantly more ethical than those who worked in solo private practice

$\underline{T}(1, 82.9) = -2.599$; counselors living and working in the same community viewed these involvements to be significantly more ethical than counselors living and working in two different communities $\underline{T}(1, 75.9) = 2.102$.

Comparison of Ethical Beliefs with Borys and Pope Results

Table 5 shows the responses of clinicians on the "ethics" form from the Borys and Pope study. In order to compare data from that study with this one, the reported Borys and Pope percentages were converted to frequencies and the Pearson chi-square test of association was used to compare responses on each item from both studies. Alpha was set at .05.

Addiction counselors' responses on each of the items on the "ethics" survey were significantly different from the combined responses of psychologists, psychiatrists, and social workers on the Borys and Pope study.

TABLE 5--ETHICAL BELIEFS RATINGS
Borys and Pope (1989)

Reported as percentages, n = 1108

1. BEHAVIOR	NEVER ETHICAL	ETHICAL UNDER RARE CONDITIONS	ETHICAL UNDER SOME CONDITIONS	ETHICAL UNDER MOST CONDITIONS	ALWAYS ETHICAL	NOT SURE	NR*
Accepting a gift worth under $10 from a client	3.0	13.0	38.4	40.1	5.0	0.4	0.2
Accepting a client's invitation to a special occasion (e.g. his/her wedding)	6.3	26.3	41.0	20.8	4.6	0.8	0.1
Accepting a service or product as payment for therapy	21.4	30.0	28.2	12.7	2.7	4.2	0.7
Becoming friends with a client after termination	14.8	38.4	32.0	10.2	2.1	1.9	0.6
Selling a product to a client	70.8	18.0	7.5	0.9	0.3	2.1	0.5
Accepting a gift worth over $50 from a client	44.9	37.0	13.1	1.4	0.8	2.3	0.5
Providing therapy to a then-current employee	57.9	26.2	10.9	2.1	0.2	2.4	0.4
Engaging in sexual activity with a client after termination	68.4	23.2	4.2	0.6	0.3	2.6	0.7
Disclosing details of one's current personal stresses to a client	26.0	39.3	29.5	2.9	1.3	0.5	0.5
Inviting clients to an office/clinic open house	26.6	24.7	21.5	15.4	5.8	5.0	0.9
Employing a client	49.9	29.5	14.5	2.8	4.2	1.5	0.5
Going out to eat with a client after a session	43.2	37.9	13.6	2.4	0.8	1.4	0.5
Buying goods or services from a client	36.7	35.4	20.6	4.7	0.7	1.5	0.3
Engaging in sexual activity with a current client	98.3	0.5	0.0	0.1	0.6	0.4	0.0
Inviting clients to a personal party or social event	63.5	29.2	4.6	0.7	0.5	1.2	0.2
Providing individual therapy to a relative, friend or lover of an ongoing client	12.6	21.4	38.8	21.4	4.2	1.0	0.5
Providing therapy to a current student or supervisee	44.4	31.0	16.0	5.4	1.0	2.0	0.4
Allowing a client to enroll in one's class for a grade	39.0	28.0	18.0	7.6	1.9	5.2	0.4

*No response
Percentage may not total 100% due to rounding.

Responses Regarding Behaviors

In Table 6 the percentages of response for each item that the 396 addiction counselors in this part of the study reported engaging in each of the listed activities are presented.

In all cases, the percentage of counselors having engaged in the behavior was greater with no or few clients than with some, most, or all clients. In no case, did a majority of respondents report having performed a behavior with at least one client. No one reported having engaged in "borrowed over $20 from a client". Respondents chose "engaged in sexual activity with an ongoing client" with at least one client with the least frequency (0.5%).

Table 7 shows the percentages of responses of clinicians on the "practices" form from the Borys and Pope study.

Respondents in the Borys and Pope study reported engaging in two behaviors with at least one client most of the time; accepting a gift worth less than $10 (85.2%), and providing concurrent individual therapy to a client's significant other (61.2%). The reported frequency of engaging in sexual relations with a current client was the same (0.5%).

TABLE 6--PRACTICE PERCENTAGES

Reported as percentages, n = 396

1. BEHAVIOR	FREQUENCY OF BEHAVIOR WHEN OPPORTUNITY PRESENT					
	NO CLIENTS	FEW CLIENTS	SOME CLIENTS	MOST CLIENTS	ALL CLIENTS	NR*
Accepted a gift worth under $10 from a client	40.4	48.2	3.0	1.0	4.0	3.3
Accepted a client's invitation to a special occasion (e.g. his/her wedding)	67.2	26.0	2.8	0.5	0.3	3.3
Accepted a service or product as payment for therapy	84.6	11.1	1.0	0.0	0.3	3.0
Become friends with a client after termination	60.6	30.3	6.1	0.0	0.0	3.0
Sold a product to a client	94.9	2.0	0.0	0.0	0.0	3.0
Accepted a gift worth over $50 from a client	95.2	1.8	0.0	0.0	0.0	3.0
Provided therapy to a then-current employee	83.4	11.4	2.3	0.0	0.0	3.0
Engaged in sexual activity with a client after termination	94.1	2.8	0.0	0.0	0.0	3.0
Borrowed less than $5 from a client	95.2	1.3	0.0	0.0	0.0	3.5
Disclosed details of your current personal stresses to a client	62.5	31.6	5.6	1.0	.3	3.0
Borrowed over $20 from client	96.8	0.0	0.0	0.0	0.0	3.3
Invited clients to an office/clinic open house	71.9	7.8	7.3	3.0	6.6	3.3
Employed a client	88.1	6.6	2.0	0.0	0.0	3.3
Went out to eat with a client after a session	86.1	9.6	1.0	0.0	0.0	3.3
Bought goods or services from a client	80.8	13.9	2.0	0.0	0.0	3.3
Engaged in sexual activity with an ongoing client	96.4	0.5	0.0	0.0	0.0	3.0
Invited client to a personal party or social event	91.9	4.8	0.3	0.0	0.0	3.0
Provided individual therapy to a relative, friend or lover of an ongoing client	55.6	24.5	13.9	1.8	1.0	3.3
Provided therapy to a then-current student or supervisor	87.9	6.6	1.8	0.5	0.0	3.3
Allowed a client to enroll in your class for a grade	94.7	1.5	0.8	0.0	0.0	3.0

*No response

Percentages may not total 100% due to rounding.

TABLE 7--PRACTICE PERCENTAGES
Borys and Pope (1989)

Reported as percentages, n = 1021

1. BEHAVIOR	FREQUENCY OF BEHAVIOR WHEN OPPORTUNITY PRESENT					
	NO CLIENTS	FEW CLIENTS	SOME CLIENTS	MOST CLIENTS	ALL CLIENTS	NR *
Accepted a gift worth under $10 from a client	14.0	56.5	11.3	5.9	11.5	0.8
Accepted a client's invitation to a special occasion (e.g. his/her wedding)	64.0	28.0	3.3	2.4	1.4	0.8
Accepted a service or product as payment for therapy	82.6	13.9	2.8	0.2	0.1	0.8
Become friends with a client after termination	69.0	26.5	3.2	0.2	0.3	0.7
Sold a product to a client	97.1	1.4	0.7	0.0	0.1	0.7
Accepted a gift worth over $50 from a client	92.4	5.8	0.3	0.2	0.2	1.1
Provided therapy to a then-current employee	87.5	9.3	1.7	0.3	0.2	1.1
Engaged in sexual activity with a client after termination	95.3	3.9	0.0	0.0	0.0	0.8
Borrowed less than $5 from a client	97.0	1.7	0.0	0.2	0.1	1.1
Disclosed details of your current personal stresses to a client	60.1	30.7	7.4	0.6	0.2	1.0
Borrowed over $20 from client	98.7	0.1	0.1	0.0	0.0	1.1
Invited clients to an office/clinic open house	88.7	3.7	3.5	1.1	2.0	0.9
Employed a client	91.2	7.5	0.4	0.1	0.0	0.8
Went out to eat with a client after a session	87.4	10.5	0.9	0.2	0.0	1.1
Bought goods or services from a client	77.6	20.5	1.1	0.1	0.0	0.8
Engaged in sexual activity with an ongoing client	98.7	0.4	0.1	0.0	0.0	0.8
Invited client to a personal party or social event	92.1	6.7	0.3	0.2	0.0	0.8
Provided individual therapy to a relative, friend or lover of an ongoing client	38.0	36.0	21.6	2.1	1.4	0.8
Provided therapy to a then-current student or supervisor	88.9	8.4	1.5	0.2	0.1	0.9
Allowed a client to enroll in your class for a grade	95.2	2.3	1.1	0.1	0.3	1.3

*No response
Percentages may not total 100% due to rounding.

Classification

As in the Borys and Pope study, ratings on the "practices" form were heavily skewed toward "never". Although the variance was restricted, a factor analysis could have been employed as a method of identifying factors, it had not been conducted in the previous study and was not conducted here.

The factors obtained in the "practices" survey results were used as a means of grouping conceptually similar items into three composite indices and summing the ratings for those items for each participant. The three dimensions were: Personal/Social Involvements, Incidental/Financial Involvements, and Dual Professional Roles.

Relation Between Addiction Counselors' Characteristics and Behavior Categories

The statistical procedures previously described (ANOVAS) were used to analyze the relations between each of the counselor characteristics and each of the three behavior categories.

Category I: Personal/Social Involvements. The occasions of reported Personal/Social Involvements were found to vary significantly by residence $F(3, 379) = .0104$; helpful/harmful $F(3, 375) = 3.76$; and recovery $F(1, 381) = 4.84$.

Post hoc Scheffe analyses showed that those who viewed outside encounters with clients to be very helpful to the client (M = 9.10) engaged in Personal/Social Involvements significantly more often than those who saw their outside encounters as neither helpful or harmful (M = 7.30).

Category II: Incidental/Financial Involvements. The frequency of reported Incidental/Financial Involvements varied significantly by theoretical orientation $F(5, 348) = 3.08$; and setting $F(5, 378) = 5.04$. Post hoc Scheffe analyses showed that counselors with a primary humanistic orientation (M = 7.09) engaged in Incidental/Financial Involvements more often than behaviorally oriented counselors (M = 5.70); those in group private practice reported engaging in Incidental/Financial Involvements (M = 7.66) more often than those in either inpatient settings (M = 5.74) or other settings (M = 5.98).

Planned contrasts showed that those in group private practice (M = 7.66) reported having engaged in Incidental/Financial Involvements significantly more often than those in solo private practice (M = 6.31), $T(1, 92.6) = -2.577$. Combined private practice counselors participated in Incidental/Financial Involvements significantly more often than all other settings combined (combined M = 6.99), $T(1, 145.2) = 3.023$.

Category III: Dual Professional Roles. The frequency of reported Dual Professional Roles varied significantly by age $F(4, 376) = 2.45$; and encounter $F(4, 379) = 2.65$.

Post hoc Scheffe analyses and planned comparisons showed no significant differences.

Comparison of Behaviors with Borys and Pope Results

The same method used for comparing participants in both studies on the "ethics" form were used to compare both groups on the "practices" form of the survey. Percentages were converted to frequencies on the Borys and Pope study and the Pearson chi-square test of association was used to compare responses on each item from both studies.

Significant differences in reported practice between the two groups was found on 7 items. Addiction counselors engaged in three behaviors less often than the Borys and Pope sample. They were "accepted a gift worth under $10 from a client", "provided therapy to a then-current employee", and "provided individual therapy to a relative, friend or lover of an ongoing client". Addiction counselors engaged in four behaviors significantly more often than psychologists, psychiatrists, and social workers. The behaviors were "become friends with a client after termination", "accepted a gift worth over $50 from a client", "invited clients to an office/clinic open house", and "employed a client".

CHAPTER 5

DISCUSSION AND SUGGESTIONS

For this study, data was collected from certified addiction counselors on their beliefs about how ethical specific dual relationship behaviors are and how frequently counselors have practiced these behaviors. This was a replication of a previous study of psychologists, psychiatrists, and social workers by Borys and Pope (1989). It is the first such study, to date, using addiction counselors as the population studied.

Validity and Interpretation Issues

Four issues need to be considered in interpreting the results of this study. First, there are very important differences between the subjects in this study and the subjects in the Borys and Pope study. A comparison of demographics between this sample and the Borys and Pope sample indicated different types of primary practice settings (outpatient clinic versus solo private practice), clients (males versus females), and theoretical orientations (cognitive versus psychodynamic). It seems logical to assume that issues faced by members of each discipline may be quite different. Given seemingly similar client circumstances, differing responses might be appropriate, depending on the differences in counselor

variables. These factors should be considered in future research.

Second, this was the first national study of ethics and addiction counselors and, as such, forms a baseline from which other studies can develop. Addiction is a major problem in this country, however, little research has been conducted looking at the unique characteristics of the therapeutic relationship between counselor and client. The subjects of this study were Certified Addiction Counselors meeting certification requirements of the International Certification Reciprocity Consortium. As such, caution should be used in generalizing to other disciplines or to other addiction professionals, including certified addiction counselors who have received their certification through another process.

Third, the "practices" instrument was not perfect and may have left room for under-reporting. For example, the scale moves from reporting "no clients" to reporting "few clients". A counselor who may have had a sexual relationship with a client once, several years before, for example, might be inclined to record the event in the "no clients" category rather than the "few clients" category because it sounds better. Counselors may have under-reported in an effort to "make a good impression".

Fourth, factors accounted for only 53% of the variance and loadings of some times were very close, making it somewhat of a problem in feeling statistically and conceptually confident about the factors themselves.

Purposes of the Study

The study had five purposes. First, to identify ethical beliefs of Certified Addiction Counselors, specifically in regard to dual relationship behaviors. Second, to determine the frequency of dual relationship behaviors practiced by Certified Addiction Counselors. Third, to compare results with those found in a previous study of psychologists, psychiatrists, and social workers (Borys & Pope, 1989). Fourth, to identify differences in response on the added demographic items, "are you a recovering alcoholic or addict?", "are you an adult child of an alcoholic or addict?", and "have you ever attended an ethics class?" And fifth, to find out how helpful or harmful addiction counselors view their encounters with clients outside of therapy.

Comparison of Responses With Borys and Pope Study

Addiction counselor responses on the "ethics" form of the survey varied significantly on all items from those of the psychologists, psychiatrists, and social workers with addiction counselors responding more conservatively. Addiction counselors appear to be very aware of dual

relationship behaviors and cautious about labeling them as being ethical. A majority of respondents rated 11 items as "never ethical" compared to a majority of the Borys and Pope respondents who rated 5 items as "never ethical".

A majority of addiction counselors claimed to have never practiced 19 of the 20 behaviors. This was slightly more conservative than the Borys and Pope study where a majority of subjects reported never having engaged in 18 of 20 variables.

There were no significant differences in response between the two groups in practice on 13 items. Of the other seven items, addiction counselors practiced four more often than the other group and three less often.

Addiction counselors report having engaged in a sexual relationship with a current client at exactly the same rate as the subjects of the previous study (.5%). They report being involved sexually with former clients at a lower rate (2.8%) than the Borys and Pope group (3.9%).

Beliefs and Behaviors Relative to Counselor Characteristics

There were no significant differences between any of the 15 counselor characteristics and items on either the "ethics" form or the "practices" form. Although over half of counselors reported being recovering alcoholics or addicts (52.6%; $\underline{n}$ = 435) and, presumably, see many of their clients and former clients in 12-step meetings or recovery

groups, they did not seem to differ from nonalcoholic/addicts in their beliefs or behaviors. The same applies for those counselors raised in alcoholic/addict homes. Almost all counselors report having attended an ethics class (92.9%; n = 768).

Gender Issues

Males viewed Personal/Social Involvements (Factor I) to be more ethical than females did. This finding fit with that of the Borys and Pope study. Unlike the Borys and Pope study, the majority of clients treated were men (59.1%). Different dynamics may operate in dual relationships when the client is male.

Practice Setting

Counselors with from 11 to 20 years of experience viewed Incidental/Financial Involvements (Factor II) as significantly more ethical than those with 1 to 10 years of experience. Those counselors in group private practice settings viewed Incidental/Financial Involvements significantly more ethical than those working in residential treatment settings. Counselors in solo private practice view these involvements as more ethical than did respondents in all other settings.

Counselors in group private practice reported engaging in Incidental/Financial Involvements more often than those in either inpatient settings or "other" settings. Those in

solo practice settings engaged in these involvements significantly more often than counselors in group private practice and combined private practice counselors participated in these involvements more often than those in all other settings together.

Counselors in solo private practice believe Dual Professional Roles (Factor III) to be significantly more ethical than those who worked in group private practice. Many counselors who are new in the field work in program settings prior to working in private practice. Often these programs have very strict rules requiring counselors not to engage in these behaviors. It appears that professionals with more years of experience or who are in private practice may get to set their own rules and can become more flexible.

Encounters

Counselors who encountered clients on a daily basis outside of counseling viewed Dual Professional Roles as significantly more ethical than those who rarely encountered clients outside the therapeutic setting. Respondents who saw their outside encounters with clients as being very helpful to the client engaged in Personal/Social Involvements significantly more often than those who saw their outside encounters as neither helpful or harmful.

Addiction and Family Background

Recovering alcoholics/addicts made up half of respondents in this study (52.6%; n = 435). Adults raised in addicted families represented (52.2%; n = 432), or again, about half. This fits with the results of Racusin et al. (1981) where 50% of clinicians were found to be from families where alcoholism or abuse had occurred. Neither of these counselor characteristics seemed to have had an effect on beliefs or behaviors of addiction counselors.

Ethics Training

Almost all counselors stated they had attended an ethics class (92.9%; n = 768) and no significant differences were found between these respondents and those who had never attended an ethics class. It is not known what constituted an ethics class to respondents. It is just as possible that attending a one-hour in-service lecture was counted as attending a one-semester graduate class. In order to determine whether training in ethics makes a difference in beliefs and behaviors, the class would have to be more clearly defined and equal numbers of counselors who have attended and counselors who haven't attended would be compared.

Implications for Future Research

This was the first national study of ethical beliefs and behaviors of addiction counselors. It was a

replication of the Borys and Pope (1989) study of psychologists, psychiatrists, and social workers. Because the two subject groups dealt with different populations, worked in different settings, and had dissimilar theoretical orientations, different results would be expected. Significant differences between the two groups were found on all of the belief items, however, significant differences were found on only 7 of the 20 behavioral items, making their practices are more similar than different.

This study is a foundation for future research in the area and raises many questions. Most addiction counselors reported encountering clients outside of counseling on a fairly regular basis with a combined 68.9% (combined $\underline{n}$ = 570) reporting contact daily, frequently, or sometimes. This study did not ask where that contact took place, whether in 12-step meetings, or elsewhere. It is not known what the rate of outside client contact is with other mental health professionals and if addiction counselors have more or less of these encounters. It would be important to explore these issues in future research.

Many counselors in this study felt that these contacts were very or somewhat helpful to the client (combined 28.8%, $\underline{n}$ = 238), or neither helpful or harmful (68.8%, $\underline{n}$ = 569). This belief certainly does not support previous

research (Bouhoutsos et al., 1983; Pope & Vetter, 1991) which concluded that 90% of clients are harmed in some way by dual relationships.

The nature of the client contact is not known. If counselors are largely seeing clients from across the room in 12-step meetings, perhaps the contact is, indeed, helpful to the client, as the counselor can serve as a role-model and ready reminder of the importance of progress in recovery.

Future research should be conducted using former clients as subjects in which they are asked the same kinds of questions as asked of counselors, such as "have you ever given a gift worth under $10 to your counselor?", "have you ever gone out to eat with your counselor after a session?", and "have you ever engaged in sexual activity with a counselor you were seeing at the time?" Clients would report how helpful or harmful each of these contacts was to them. Their answers could then be compared to counselor response.

If we are to believe the self-report of addiction counselors, it appears that they are not engaging in dual relationship behaviors at alarming rates. This finding is confusing, however, based on the results of a recent survey of ethical complaints against addiction counselors to certification boards, where St. Germaine (1993) found that

the most common complaint was for sexual involvement with a current client (16.40%). When all dual relationship complaints were combined, they represented almost one third (28.49%) of complaints against addiction counselors. One explanation may be that official complaints are on the rise because clients are more aware about their rights and how to make an official complaint than in the past.

Thorn, Shealy, and Briggs (1993) report that counselors and clients feel anxious when discussing the topic of counselor-client intimacy. Every effort was made to reduce that anxiety by protecting anonymity, however, the forms could be changed to facilitate even more candid responses.

The ethical beliefs scale could be simplified to ask whether an item is ethical or unethical as did Gibson and Pope (1993) in their recent study of certified professional counselors' ethical beliefs. When measuring practices, changing the scale to read "number of clients" would gather more accurate data than "some" and "few". The scale could read "1 client", "2 - 5 clients", "6 - 10 clients", and so forth.

It has been well established in the literature that sexual dual relationships can be harmful and all mental health codes of ethics forbid them, however, it has not been documented that other types of dual relationships are

also harmful to the client. It is possible that some types of dual relationships are beneficial, particularly when dealing with addictive disorders.

Another aspect to consider is what role recovery plays in the counselor's ability to function well and set healthy boundaries. Is it possible that because of the influence of Alcoholics Anonymous and similar programs, addiction counselors are more aware of the importance of boundary-setting with clients than other mental health professionals?

Lastly, how dual relationships impact the counselor needs to be examined. Much is written about harmfulness of dual relationships to clients but little, if anything, has been written about the consequences of dual relationships to the counselor. Some dual relationship situations are not so straightforward and easy to avoid. In the study of ethical complaints against addiction counselors, St. Germaine (1993) found the second most common complaint was impaired counselor, usually through the use of alcohol and drugs.

What relationship might dual roles have in recovering counselors experiencing relapse? What stresses do counselors endure once involved with a client, especially when the counselor wants to end it? How helpful are other professionals to the individual in this circumstance? How

does the counselor balance the needs of the clients with his or her own needs?

This is just the beginning of examining the issue of dual relationships in the addiction counseling field. Future research will be able to successfully answer the questions raised in this study.

APPENDIX A

Survey Form: Beliefs

THERAPEUTIC PRACTICES SURVEY

Please complete both sides of this form regardless of whether you have ever provided psychotherapy services.

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

In responding to each item, please consider only psychotherapy with adult clients (including family therapy and parent guidance). Unless otherwise indicated, items refer to a therapist's behavior with clients he or she is currently treating.

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

Please complete the following information.

1. ___ Female ___ Male

2. Age: ___ years

3. Marital Status: ___ Married ___Cohabitating ___Separated or Divorced ___Single

4. Are you currently involved in any advanced degree or specialization program in mental health? ___ Yes ___No If so, for what degree or specialization?_____

5. Have you provided counseling services at any time within the last 5 years? ___Yes ___No If yes, please answer questions 7 - 15. If not, please answer questions 13 - 15.

6. Total number of years you have provided counseling services: _____

7. Many clinicians are guided by a number of theoretical orientations in their clinical work. Please rank order from 1 to 6 the following theoretical orientations in terms of the degree to which each has influenced your psychotherapy work (with 1 = greatest influence)

___Behavioral ___Cognitive ___Gestalt ___Existential ___Psychodynamic
Other/Please specify: _____ ___
Orientation rank

8. In the past five years, what proportion of your clients have been:
___% Youth (under 18)
___% Adult men
___% Adult women
_____
100%

9. Which one of the following best describes the primary clinical setting in which you most recently provided counseling services?
___ Solo private practice ___Group private practice ___ Outpatient clinic
___Inpatient facility ___ Residential/halfway ___Other_____
Specify

10. While working in that setting, how socially isolated do/did you feel?
___ Not at all isolated
___ Mildly isolated
___ Moderately isolated
___ Extremely isolated

11. Where do/did you reside while working at your primary clinical setting?

___ I live(d) and work(ed) within the same small town or rural community.
___ I live(d) and work(ed) within the same suburban area.
___ I live(d) and work(ed) within the same urban area.
___ I live(d) and work(ed) in 2 different communities.

12. How often do/did you unintentionally encounter current or former counseling clients outside of therapy sessions?
___ Every day ___ Sometimes ___ Never ___ Frequently ___Rarely

13. How helpful or harmful to your clients have your encounters (intentional or unintentional) outside of therapy sessions been?
___Very Helpful ___Somewhat Helpful ___Neither Helpful or Harmful
___Somewhat Harmful ___Very Harmful

14. Are you a recovering alcoholic or addict? ___ Yes ___ No.

15. Are you an adult child of an alcoholic or addict? ___ Yes ___ No.

16. Have you ever attended an ethics class? ___ Yes ___No.

If the return envelope is damaged or misplaced, please return survey to:

Jacquelyn St. Germaine, M.S., M.A., C.A.D.A.C.
3131 N. Country Club, #206
Tucson, Az. 85716

APPENDIX B

Survey Form: Practices

THERAPEUTIC PRACTICES SURVEY

If you have provided psychotherapy services at any time in the past 5 years, please complete both sides of this form. If you have not provided services in the past 5 years, please skip Section I (below) and complete only Section II (other side).

Below are listed a number of behaviors which therapists may engage in as part of their clinical practice. Please indicate by circling the appropriate number, the proportion of clients with those you have engaged in the behavior when the opportunity was present ALL CLIENTS (5), MOST CLIENTS (4), SOME CLIENTS (3), FEW CLIENTS (2), or NO CLIENTS (1). Use ALL CLIENTS (5) if you have engaged in the behavior, whenever the opportunity was present. Use NO OPPORTUNITY (0) if there was no opportunity to engage in the behavior in any settings in which you have provided psychotherapy services. Use NO CLIENTS (1) of at least one setting you have worked in offered the opportunity to engage in the behavior but you chose not to.

In responding to each item, please consider only psychotherapy with adult clients (including family therapy and parent guidance). Unless other wise indicated, items refer to behavior engaged in with individuals who were in ongoing treatment at the time.

1. BEHAVIOR	FREQUENCY	OF	BEHAVIOR	WHEN	OPPORTUNITY	PRESENT
	ALL CLIENTS	MOST CLIENTS	SOME CLIENTS	FEW CLIENTS	NO CLIENTS	NO OPPORTUNIT
Accepted a gift worth under $10 from a client	5	4	3	2	1	0
Accepted a client's invitation to a special occasion (e.g. his/her wedding)	5	4	3	2	1	0
Accepted a service or product as payment for therapy	5	4	3	2	1	0
Become friends with a client after termination	5	4	3	2	1	0
Sold a product to a client	5	4	3	2	1	0
Accepted a gift worth over $50 from a client	5	4	3	2	1	0
Provided therapy to a then-current employee	5	4	3	2	1	0
Engaged in sexual activity with a client after termination	5	4	3	2	1	0
Borrowed less than $5 from a client	5	4	3	2	1	0
Accepted a handshake offered by a client	5	4	3	2	1	0
Felt sexually attracted to a client	5	4	3	2	1	0
Disclosed details of your current personal stresses to a client	5	4	3	2	1	0
Borrowed over $20 from client	5	4	3	2	1	0
Invited clients to an office/clinic open house	5	4	3	2	1	0
Employed a client	5	4	3	2	1	0
Went out to eat with a client after a session	5	4	3	2	1	0
Bought goods or services from a client	5	4	3	2	1	0
Engaged in sexual activity with an ongoing client	5	4	3	2	1	0
Invited client to a personal party or social event	5	4	3	2	1	0
Provided individual therapy to a relative, friend or lover of an ongoing client	5	4	3	2	1	0
Provided therapy to a then-current student or supervisor	5	4	3	2	1	0
Allowed a client to enroll in your class for a grade	5	4	3	2	1	0

Please complete the following information.

1. ___ Female ___ Male

2. Age: ___ years

3. Marital Status: ___ Married ___Cohabitating ___Separated or Divorced ___Single

4. Are you currently involved in any advanced degree or specialization program in mental health? ___ Yes ___No If so, for what degree or specialization?_____

5. Have you provided counseling services at any time within the last 5 years? ___Yes ___No If yes, please answer questions 7 - 15. If not, please answer questions 13 - 15.

6. Total number of years you have provided counseling services: _____

7. Many clinicians are guided by a number of theoretical orientations in their clinical work. Please rank order from 1 to 6 the following theoretical orientations in terms of the degree to which each has influenced your psychotherapy work (with 1 = greatest influence)

___Behavioral ___Cognitive ___Gestalt ___Existential ___Psychodynamic
Other/Please specify: _____ ____
Orientation rank

8. In the past five years, what proportion of your clients have been:
___% Youth (under 18)
___% Adult men
___% Adult women

_____
100%

9. Which one of the following best describes the primary clinical setting in which you most recently provided counseling services?
___ Solo private practice ___Group private practice ___ Outpatient clinic
___Inpatient facility ___ Residential/halfway ___Other_____
Specify

10. While working in that setting, how socially isolated do/did you feel?
___ Not at all isolated
___ Mildly isolated
___ Moderately isolated
___ Extremely isolated

11. Where do/did you reside while working at your primary clinical setting?

___ I live(d) and work(ed) within the same small town or rural community.
___ I live(d) and work(ed) within the same suburban area.
___ I live(d) and work(ed) within the same urban area.
___ I live(d) and work(ed) in 2 different communities.

12. How often do/did you unintentionally encounter current or former counseling clients outside of therapy sessions?
___ Every day ___ Sometimes ___ Never ___ Frequently ___Rarely

13. How helpful or harmful to your clients have your encounters (intentional or unintentional) outside of therapy sessions been?
___Very Helpful ___Somewhat Helpful ___Neither Helpful or Harmful
___Somewhat Harmful ___Very Harmful

14. Are you a recovering alcoholic or addict? ___ Yes ___ No.

15. Are you an adult child of an alcoholic or addict? ___ Yes ___ No.

16. Have you ever attended an ethics class? ___ Yes ___No.

If the return envelope is damaged or misplaced, please return survey to:

Jacquelyn St. Germaine, M.S., M.A., C.A.D.A.C.
3131 N. Country Club, #206
Tucson, Az. 85716

APPENDIX C

Cover Letter

College of Education
Department of Educational Psychology

THE UNIVERSITY OF
ARIZONA
TUCSON ARIZONA

Tucson, Arizona 85721
(602) 621-7825
Fax: (602) 621-9271

March 10, 1993

Dear Addiction Counselor:

I am a Ph.D. Candidate in the Educational Psychology Department at the University of Arizona. For my dissertation I am doing a national survey of 2080 United States and Canadian addiction counselors to study ethical beliefs and behaviors. Your name has been randomly selected to participate and your participation is completely voluntary. By returning the enclosed questionnaire, consent is assumed to be given.

Please complete the attached survey form (front and back) and return it in the provided envelope by March 26, 1993. It should take approximately 20 minutes or less of your time to fill out. Do not put your name on the survey so that complete anonymity is assured due to the sensitive nature of some of the questions.

No similar work has been done in our field and this survey represents ground-breaking research which can benefit you and the field by providing information that we don't currently have. If you would like a summary of the results, please send a self-addressed stamped envelope.

I appreciate your cooperation.

Sincerely,

Jacquelyn St. Germaine

Jacquelyn St. Germaine, M.S., M.A., C.A.D.A.C.
Ph.D. Student
Educational Psychology

APPENDIX D

Letter of Permission, D. Borys

Debra S. Borys, Ph.D.
1100 Glendon Avenue
Suite 1752
Los Angeles, California 90024
(310)208-8992
(213)206-5662
XXXXXXXXXX

May 30, 1993

Jacquelyn St. Germain, Ph.D.
3131 N. Country Club Dr. #206
Tucson, AZ 85716

Dear Dr. St. Germain:

This letter is to confirm that you have my permission to use my Therapeutic Practices Survey in your dissertation research, to reprint it, or an adaptation of it, in your dissertation, and to reprint my study results in your dissertation.

Best wishes in the future and I look forward to hearing about your results.

Sincerely,

Debra Borys, PhD

Debra Borys, Ph.D.

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