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ETHICAL BELIEFS AND PRACTICES:

DO PSYCHOLOGISTS DIFFER FROM

OTHER HEALTH-CARE PROFESSIONALS

by

Gary Percival

A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF SCIENCE

in

Psychology

UTAH STATE UNIVERSITY
Logan, Utah

1992

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Gary Percival

TABLE OF CONTENTS

Page

ACKNOWLEDGMENTS ii

LIST OF TABLES v

LIST OF FIGURES vi

ABSTRACT vii

CHAPTER

I. INTRODUCTION 1

Background 1
Problem Statement 2

II. REVIEW OF LITERATURE 4

What is Ethics? 4
Ethical Codes versus Law 5
History of Ethics 6
Ethical Codes for Psychologists 9
What are Ethical Dilemmas? 10
Trends in Litigation and Complaints to Ethical Committees 11
Studies on the General Ethical Behaviors of Psychologists 15
Dual Relationships 16
Inappropriate Professional Practice 18
Confidentiality 19
Ethical Knowledge and Ethical Behavior 20
Benefits of Knowing the Normal Ethical Behaviors and Beliefs of Psychologists and Other Health-Care Professionals 21
Criticisms of the Studies of Ethical Beliefs and Behaviors 22
Summary 23

III. PURPOSE AND OBJECTIVES 25

IV. METHODS 26

Subjects 26
Procedures 28
Measures 28

V. RESULTS 30

Demographic Characteristics 30
Ratings of the 99 Behaviors 34
Behaviors Universally Accepted as Ethical 34
Behaviors Universally Accepted as Unethical 59

Controversial Behaviors 61
Expected Discrepancies 65
Ethical Differences Across Health-Care Professions 65
Written Comments from Respondents 71
Comparison to Pope 76

VI. DISCUSSION 83

Reported Ethical Beliefs and Practices Across Discipline 83
Gender Differences 85
Ethical Attitudes and Education 86
Problem and Controversial Items 88
General Comparison to Pope, Tabachnick, and Keith-Spiegel 90
Special Issues in the Area of Confidentiality 92
Special Issues in the Area of Dual Relationships 95
Special Issues in the Area of Professional Practice 100
Limitations 102
Face Validity of the Survey 103
Importance of the Current Study 104
Questions for Further Research 105
Conclusion 108

REFERENCES 110

APPENDICES 116

APPENDIX (A): Questionnaire 117

Cover Letter 118

APPENDIX (B): Breakdown of Questionnaire Items by Category 123

Dual Relationships 124
Professional Practice 125
Confidentiality 127

LIST OF TABLES

Table		Page
1	Ethical Cases On-going, Opened, Active and Closed by the APA Ethics Committee: 1983 - 1990	12
2	Issues in Ethical Violations Reported to APA Ethics Committee in 1988, 1989, and 1990	13
3	The Number of Professional Articles Written in the Areas of Confidentiality, Dual Relationships, and Professional Practice for the Mental Health Professions and the Medical Professions	16
4	Membership of the AAPB by Discipline	27
5	Demographic Characteristics of AAPB Members Providing Usable Data Compared to Total AAPB Membership	31
6	Percentage of Respondents Who Responded in each Category to the Question "How Ethical is this behavior?"	35
7	Percentage of Respondents Who Responded in each Category to the Question "How Often does this Behavior Occur in your Practice?"	44
8	Results of Univariate F-Tests for the Effect: Certification Status within Licensure Status within Educational Level and Discipline (DF = 12,471)	68
9	Results of Univariate F-Tests for the Effect: Licensure Status within Educational Level and Discipline (DF = 6,12)	69
10	Results of Univariate F-Tests for the Effect: Educational Level and Discipline (DF = 5,6)	70
11	Results of Univariate F-Tests for the Effect: Respondents' Age (DF = 6,511)	72
12	Results of Univariate F-Tests for the Effect: Respondents' Years in Practice (DF = 4,504)	73
13	Items Significantly Related to Gender on the "How Ethical is this Behavior" Scale (df = 5, p < .001)	74
14	Items Significantly Related to Gender on the "How Often does this Behavior Occur in your Practice" Scale (df = 5, p < .001)	75

LIST OF FIGURES

Figure		Page
1	Percentage of responses to behavior items in each category from the confidentiality scale.	53
2	Percentage of responses to behavior items in each category from the dual relationship scale.	54
3	Percentage of responses to behavior items in each category from the professional practice scale.	56
4	Mean response by education level of reported ethical beliefs for controversial items from the dual relationship scale.	62
5	Mean response by education level of reported ethical beliefs for controversial items from the professional practice scale.	63
6	Mean response by education level of reported occurrence in practice for controversial items from all scales.	63
7	Response rate from current survey on behavior items where a high response rate in the often and always ethical categories and in the never and rarely occurs categories were expected.	66
8	ANOVA table used to analyze the results of this survey.	67
9	Comparison of mode responses from current survey to similar items from Pope et al. (1987) for the question: How ethical is this behavior?	77
10	Comparison of mode response from current survey to similar items from Pope et al. (1987) for the question: How often does this behavior occur in your practice?	80

ABSTRACT

Ethical Beliefs and Practices: Do Psychologists Differ from

Other Health-Care Professionals

by

Gary Percival, Master of Science

Utah State University, 1991

Major Professor: Dr. Sebastian Striefel
Department: Psychology

Ethical codes and principles, and laws govern the behavior of health-care professionals. Yet, the impact that ethical codes and laws have on the actual moral behaviors of health-care professionals is relatively unknown. A survey on the ethical beliefs and practices of health-care professionals was sent to the United States membership of the Association for Applied Psychophysiology and Biofeedback. AAPB's heterogeneous membership offers a unique opportunity to compare the ethical beliefs and behaviors of professionals across various health-care professions, educational levels, licensure and certification statuses, age, years in practice, and gender. The survey examined the respondents' ethical beliefs and practices in the domains of confidentiality, dual relationships, and professional practice.

Five hundred thirty-six surveys were returned completed. The results of the survey indicate that all respondents have substantially the same reported ethical beliefs and practices across the three domains. There were no statistically significant differences between the reported ethical beliefs or practices when compared across disciplines, educational levels, licensure or certification statuses, age, or years in practice. Statistically significant gender differences were found.

(134 pages)

CHAPTER I

INTRODUCTION

Background

When clients seek assistance from health-care professionals, they expect to receive services that will be in their best interest. Generally they do, but not always. A small number of clients are victims of health-care professionals' misconduct. Because of those few who intentionally or unintentionally take advantage of their position to the detriment of their clients, laws and ethical principles are established to govern the moral behavior and practices of psychologists and other health-care professionals. Laws are standards, restrictions, and requirements established by statute. Local, state, and federal governments establish laws to protect those who live under their jurisdictions. Laws tend to be reactive; they are developed and changed according to social and political pressures (Corey, Corey, & Callanan, 1988).

Ethical principles are statements or beliefs about moral values and behaviors. Ethical principles come in two forms: "Mandatory Ethics," or compliance with laws and/or written ethical policies; and "Aspirational Ethics," or going beyond simple compliance with laws and policies and taking additional action to protect the best interest of the client (Corey et al., 1988). Ethical behavior on the aspirational level usually occurs within the confines of laws and established ethical codes, yet at times, results in deviation from formal ethical principles, after careful thought and consultation (Corey et al., 1988). For example, a professional discovers that a child has been abused by a parent. Health-care professionals following mandatory ethics would simply report the incident to the proper authorities as required by state law, whereas health-care professionals following aspirational ethics would go beyond simple reporting. Before reporting an incident they would explore options, (e.g., consult with a colleague and lawyer) and when they reported the incident they would take whatever action necessary (i.e., recommendations to the authorities, testifying in court) to assure that their client receives the help they need without being revictimized by the legal system.

Problem Statement

The values of society and the roles of health-care professionals are always changing (Pope, 1990; Stromberg et al., 1988). To keep up with these changes, formal ethical principles and laws have been created and are revised to meet the changing demands. The effects that society's changing values and roles have on the moral beliefs of health-care professionals are written about and discussed in professional journals, newsletters, and other professional and lay publications on a theoretical level. The actual impacts these social changes make on the every day practice of psychologists and other health-care professionals are relatively unknown.

At times, written ethical principles conflict with other written ethical principles, with laws or with the aspirational ethics of a given professional (Pope & Bajt, 1988). When this occurs, health-care professionals are faced with an ethical dilemma. Health-care professionals will encounter many ethical dilemmas in their practice. An ethical dilemma is a situation in which the health-care professional must make a moral judgment between two or more choices concerning the course of action that should be taken (Rapp, 1984). The wrong decision could start a chain of events that could harm the client, ruin the professional's career, and tarnish the public image of the health-care profession.

All the laws, ethical principles, and discussions on moral behavior are only useful if psychologists and other health-care professionals incorporate them into actual behaviors in their professional activities. While theoretical values have been discussed with regularity, the actual moral behaviors of health-care professionals have been largely ignored. There are many books and papers on theoretical values, but there are few that discuss the actual ethical behaviors and beliefs of the majority of health-care professionals. A basic lack of knowledge exists as to the ethical behaviors of practicing psychologists and other health-care professionals.

By continual study of the ethical beliefs and practices of psychologists and other health-care professionals, the ethics committees of the various professional organizations will have a greater knowledge base from which to draw when establishing ethical guidelines. This

protecting the welfare of the clients they serve. An understanding of the ethical beliefs and behaviors of health-care professionals can serve many important functions. First, as an evaluation of how well current training programs are doing in establishing a sense of ethical knowledge and behavior in their students. Second, as an indicator of what ethical areas need to be covered in continuing education experiences for psychologists such as workshops, newsletters, seminars, and conferences. Third, as a guide to the rewording and establishment of clear and understandable ethical principles, especially in controversial areas. Fourth, the treatment of clients is becoming increasingly multidisciplinary across the health-care professions. As various professionals work together, a comparison of their ethical beliefs and behavior may help them work together more efficiently. Finally, ethical behaviors and conduct could be examined to see if they distinguish the licensed or certified professional from those who are not. This may help those who determine licensure and certification standards in creating more efficient licensing and certification procedures.

The purpose of this study is to expand the knowledge available about the ethical beliefs and behaviors of psychologists and other health-care professionals. This study will examine the reported ethical beliefs and behaviors of the members of the Association for Applied Psychophysiology and Biofeedback (AAPB) by asking them to respond to a questionnaire about ethical beliefs and practices. The AAPB is an interdisciplinary organization made up of psychologists and other health-care professionals and paraprofessionals; as such the differences and similarities of ethical behaviors between these groups can be examined.

CHAPTER II

REVIEW OF LITERATURE

What is Ethics?

The word "ethics" is derived from the Greek word "ethos," which means character, custom, usage or habit. A word often used as a synonym for ethics is "morality," which is derived from the Latin word "moris" or manner, custom, or habit (MacKenzie, 1901; Reese & Fremouw, 1984). MacKenzie (1901) defined ethics as "The science of the ideal in conduct." (p. 1). In 1933, the Oxford English Dictionary defined ethics as "the science of morals," (Vol. 3, p. 312). According to Webster's New World Dictionary, ethics is "1. The study of standards of conduct and moral judgment 2. the system of morals of a particular person, religion, group, etc.," and "ethical" is "1. having to do with ethics; of or conforming to moral standards 2. conforming to professional standards of conduct" (p. 210).

There are two main categories of ethics, theoretical and practical (Slaatte, 1988). Theoretical ethics is usually within the domain of philosophers. Slaatte (1988) describes theoretical ethics providing

> us with the fundamental theories that give intellectual integrity or "backbone" to applied ethics. It gives principles to the various areas and problems of practical ethics. -- Though it may not always be absolutely convincing it represents the best thinkers have managed to develop upon suggesting intellectually how to attain the so-called good life. (p. xi)

Theoretical ethics is the moral reasoning behind practical ethics, and practical ethics is putting theoretical ethics to use when making decisions that may affect others.

Practical ethics is further subdivided into two main categories, mandatory and aspirational ethics. "Mandatory ethics" is strict adherence to ethical guidelines and legal mandates. Health-care professionals who strictly follow written ethical guidelines and legal mandates engage in behavior that may protect them from law suits and other punitive actions, by the legal system and professional organizations (Corey et al., 1988; Griffith, 1980; Sheldon-Wildgen, 1982). Many psychologists and other health-care professionals believe that ethical codes and laws are too

restrictive, conflict with each other, and are often a hindrance in providing effective services to their clients (Ansell & Ross, 1990; Corey et al., 1988; Griffith, 1980, Striefel, 1989b). Instead of obeying the "letter of the law" these health-care professionals believe that "aspirational ethics" is a better creed. Aspirational ethics is going beyond simple compliance with laws and ethical codes. Psychologists and other health-care professionals demonstrate aspirational ethics when they are continuously sensitive to the effects of their actions on the welfare of their clients, and when they base their ethical decisions on their client's welfare. Most often behaviors on the aspirational level will be within the bounds of formal legal and ethical codes, but at times deviations from these formal principles will occur to protect the welfare of the client, not, however, without much thought and consultation with experts in the area questioned (Corey et al., 1988).

In the field of psychology, "ethics" is defined by practice, as a set of principles subscribed to by the members of a professional psychological organization and "ethical" is defined as conforming to those standards. Ethical standards are designed to guide the professional behavior of psychologists. These ethical guidelines are a form of self-government and are an attempt by professional organizations to avoid restrictive government regulation (Corey et al., 1988). While the problems associated with ethical violations have been and continue to be discussed and written about in a theoretical sense (Bernard, Murphy, & Little, 1987; Roswell, 1989; Sheldon-Wildgen, 1982) the extent to which psychologists and other health-care professionals practice or conform to their ascribed "ethical principles" is generally unknown (Conte, Plutchik, Picard, & Karasu, 1989; Pope, Tabachnick, & Keith-Spiegel, 1987; Reese & Fremouw, 1984).

Ethical Codes versus Law

Ethical codes or principles should not be confused with laws. Local, state, and federal governments establish laws to protect the welfare of society as a whole. Laws are legal mandates about what is and is not acceptable behavior (Rapp, 1984). Laws for psychologists cover areas

like who can and can not be called a psychologist, training requirements for licensure in psychology, and the limits of privileged communication for psychologists. Laws are generally not flexible and for each proven violation there is a consequence as determined by the judicial system. These consequences include such things as fines, loss of one's professional license, and jail time.

The professional organizations to which one chooses to belong establish ethical codes or principles (i.e., by a committee of one's peers). They are philosophical statements about right and wrong. Ethical codes are established first, to protect the welfare of the individual client, subject, employee, or student; second, to protect the welfare of the health-care professional; and third, to protect and develop the public image of the health-care professions. Ethical principles cover areas such as professional responsibility, competence, moral and legal standards, public statements, the extent and limits of confidentiality, providing for the welfare of the consumer, involvement in other professional relationships, assessment techniques, and research (AAPB, 1990; APA, 1990; Gaul, 1989). Violations of ethical principles include consequences such as censures, reprimands, probation, and expulsion from the organization (AAPB, 1990; APA, 1990; Stromberg et al., 1988).

History of Ethics

The first writings about ethics come from the ancient Greeks. Hippocrates (about 460 B.C.) developed the first ethical code when he created the Hippocratic oath (Hothersall, 1990). Socrates (469-399 B.C.) took aspirational ethics to its extreme when he refused to change his death sentence or escaping from his jail cell, because it would have looked as if he loved life more than wisdom if he did not accept his sentence (Slaatte, 1988). Socrates' student, Plato (427-327 B.C.), followed Socrates' belief that knowledge was virtue but he also believed that all men where created differently and thereby could obtain different degrees of knowledge. Plato argued that the differences in men were God given and that men should accept their various roles in life and work toward the good of the whole (Slaatte, 1988).

Aristotle (385-322 B.C.) was Plato's student and took Plato's ethics one step further. Under Aristotle's ethics, men should work for the common good of the whole and the whole should provide for the good of the men (Hothersall, 1990; Slaatte, 1988). Epicurus (341-270 B.C.) was a hedonist; he believed that happiness was an end in itself and that man did not have to work toward some common goal. This was in direct opposition to Plato's view that man should work for the common good (Slaatte, 1988).

Zenos (336-264 B.C.) developed the last major ancient Greek ethical philosophy when he founded the school known as Stoics. Stoics were the first philosophers to see free will as basic to life. Good and evil were concepts created by man, and through self-discipline man could become whatever he wanted. Stoicism dominated the intellectual world for 500 years before Christianity. With the arrival of Christianity the major ethical influence returned to Plato's doctrine of working for the good of the state. During the ethical reign of Christianity, mandatory ethics was the rule. The Church created the moral standards and customs and made sure that all abided by them (Hothersall, 1990; Slaatte, 1988).

The establishment of the Gutenberg press in 1450 A.D. was the beginning of the end for the Catholic Church's hold on ethical beliefs (Hothersall, 1990). With the printing press, books became more readily available and knowledge and ideas were more readily exchanged throughout the world. Printed journals are still the major source for the dissemination of scientific knowledge and thought, including ethical beliefs and arguments.

Thomas Hobbes (1588-1679 A.D.) expounded a pro-mechanistic form of hedonism. Man is basically selfish and all social contracts are designed to benefit the individual. The naturalist or pre-behavioral point described by Hobbes was held by others such as Copernicus, Galileo, and Harvey, but Hobbes (1651) was the first to write about this view in his book Leviathan (Hothersall, 1990; Slaatte, 1988).

Many of Hobbes contemporaries had to face their own ethical dilemmas. Copernicus (1473-1543 A.D.) delayed the publication of his heliocentric view of the universe because he

made an ethical decision that the world was not ready for his view. Bruno (1548-1600) was burned at the stake for defending Copernicus's view because his Aspirational ethics would not let him discount what he believed to be true. The Catholic Church censured Galileo (1564-1642) and forced him to retract his beliefs (an act that he never fully did) or face a fate similar to Bruno (Hothersall, 1990).

As the Church's civil power weakened, there was no organization that immediately took its place. During this time ethical theory flourished but ethical control or mandatory ethics were almost nonexistent. Philosophers like Immanual Kant (1724-1804) and David Hume (1711-1776), and intellectuals like John Stuart Mill (1806-1873) reintroduced and argued for various forms and combinations of ethical theories exposed by the ancient Greeks (Hothersall, 1990; Slaatte, 1988). The impact of this reintroduction and refinement of ancient Greek philosophy shaped the way psychology was thought of and the way psychological research was conducted, but it originally had little effect on the establishment of formal ethical codes.

This does not mean that the early beginnings of psychology were devoid of ethical behavior. Brentano (1838-1917) and Stumpf (1848-1936) gave up their positions in the Catholic Church when the Church's doctrine went against their personal beliefs. Magendie's (1785-1855) and Bell's (1774-1842) research involving breaking the spinal columns of animals while the animal was still alive was considered cruel, and antivivisectionists still use the research of Magendie and Bell as examples of inhuman practices. In 1911, Stumpf's assistant Pfungst debunked the theory that Clever Hans, the counting horse, could actually do mathematics. This case had influence on the ethics of psychological research and how experimenters could use subtle cues to obtain desired results (Hothersall, 1990).

Although there was no formal control over mandatory ethics, the great thinkers in the health-care professions continued to monitor themselves on an aspirational level. Sanctions could not be brought against men like Bartholow who in 1874 directly stimulated a woman's brain. She

later died as a result of the experiment. The public outcry was sufficient to force Bartholow to resign his academic position and to leave Cincinnati (Hothersall, 1990).

Ethical Codes for Psychologists

The development of formal ethical codes for psychologists began in 1953 with the publication of The American Psychological Association's "Ethical Standards of Psychologists" (APA, 1953). The "Ethical Standards of Psychologists" was published shortly after World War II as a reaction to society's moral outcry against the experiments conducted by scientists in Nazi Germany (Reese & Fremouw, 1984). Since that time ethics in psychology, for psychologists, have focused on the development of a set of theoretical moral standards rather then studying moral behavior. These theoretical values are argued and bantered back and forth, while the study of the actual ethical behaviors of psychologists is relatively untouched (Pope et al., 1987, 1988; Reese & Fremouw, 1984). As a result of this theoretical approach to ethics, changes in the codes for psychologists have been in reaction to the demands of society or the legal system, instead of being based on the actual behaviors of psychologists and the consequences of professionals' behaviors on clients, other psychologists, and psychology as a profession. An example of this is the recent changes in the APA Ethical Principles of Psychologists. In 1986, the APA created an Ethics Subcommittee to begin the work of revising the APA's code of ethics. Also in 1986, the Federal Trade Commission (FTC) began an investigation of the APA ethics code. In 1989, the FTC determined that the APA's code of ethics was in violation of the federal antitrust laws. In reaction to this finding the APA's Ethical Principles of Psychologists were immediately changed to meet the demands of the FTC (APA Ethics Committee, 1990). Meanwhile the Ethics Subcommittee continues to work on its revision of the ethical codes, publishing a proposed draft of the ethical codes in the June 1991 Monitor. The revision seems to be based mostly on the comments of professionals and the requirements of the legal system without considering incorporating normative data into the decision making process.

Some other health-care professions have even longer histories of ethical development. Ethical codes for the medical profession began in ancient Greece when Hippocrates made his oath, and nurses first formalized their ethical beliefs when the Florence Nightingale Pledge was introduced in 1893 (Fowler, 1989). Every major organization of health-care professionals has developed a code of ethics to govern the professional conduct of its members.

What are Ethical Dilemmas?

Ethical codes often include conflicting principles and conflict with established laws (Corey et al., 1988; Pope & Bajt, 1988). When this occurs the psychologist must make a decision as to what course of action is in the best interest of the client. These situations are referred to as ethical dilemmas. Ethical dilemmas occur frequently in the practice of the health-care professions. The presence of an ethical dilemma should not lead one to infer that the health-care professional has engaged in unethical behavior. It simply means that the health-care professional must choose between two or more potentially correct courses of action (Rapp, 1984), hopefully keeping the welfare of the client foremost in mind. Some common dilemmas are: can fees be raised during the course of treatment?; can deception be used as a treatment technique?; and can a therapist become socially involved with a client? In short, any action or decision that affects the welfare of a client is a moral decision. Any moral decision that has more than one possible appropriate behavior choice for professionals, creates a moral dilemma. Moral dilemmas are ethical dilemmas. Any time a health-care professional has to make a choice, in an ethical dilemma, it is possible to make the wrong choice. Given the possibility of making a wrong choice, it is in the health-care professional's best interest to acquire the knowledge and decision making skills required to make these important choices. One source of knowledge that has been overlooked is how the majority of health-care professionals handle common ethical dilemmas (Pope et al., 1987).

Trends in Litigation and Complaints to Ethical Committees

According to a study conducted by the American Psychological Association's Ethics Committee (1988), the number of ethical violations being reported is on the rise. The yearly average number of ethical complaints reported to this committee during 1983 and 1984 was 56.5. This average rose 56% to 88 cases per year during 1986 and 1987.

In 1988, 311 written inquiries were received by the APA Ethics Committee. One hundred ninety-eight of these cases were dropped because the complainants chose not to proceed, 89 of these cases resulted in formal proceedings, and 24 were opened as preliminary investigations (APA Ethics Committee, 1990). In 1990, 275 written inquiries were received by the APA Ethics Committee; of these, an estimated 143 ethical cases will be opened as preliminary investigations or formal cases (APA Ethics Committee, 1991). Table 1 presents the number of ethical cases opened and closed since 1983 and Table 2 shows the issues involved in the ethical cases that were opened in 1988, 1989, and 1990.

Whether these changes are due to the increased incidence of unethical behavior or to an increased awareness of ethical issues is not known. Of concern, is the increase in the number of ethical complaints to the APA Ethics Committee that have been paralleled by increases in the number of malpractice suits against psychologists and in the cost of malpractice insurance for psychologists. Between 1982 and 1984 a yearly average of 153 malpractice suits were filed against psychologists. The yearly average for malpractice suits increased to 239 for 1985 and 1986. In 1980 the malpractice insurance premiums from the American Home Insurance Company were $50 a year. In 1987 the premium for minimum coverage of $300,000 had increased to $300 a year, for members of the American Psychological Association, and $450 a year, for non-members (Roswell, 1989). Currently the 43,000 APA members who are insured through the APA Insurance Trust are paying approximately $25 million per year for insurance coverage for an average of $581 per year, per member (APA Monitor, 1991a, 1991b).

Table 1

Ethical Cases On-going, Opened, Active a d Closed by the APA Ethics Committee: 1983 - 1990*

Year	On-going	Opened	Total Active	Closed
1983	65	59	124	74
1984	50	55	105	56
1985	49	73	122	75
1986	47	91	138	52
1987	86	90	176	80
1988	96	91	187	72
1989	115	91	206	83
1990	123	92	215	62
1991	153	-	-	-

* Adapted from Report of APA Ethics Committee, 1991

This upward trend in malpractice suits and rising insurance costs seems to be effecting all of the health-care professions. The cost of professional liability for medical doctors has increased over 300% since 1980 (Reynolds, Rizzo, & Gonzalez, 1987), paralleling a like increase in the number of malpractice suits (Weinstein, 1988).

Of the ethical complaints brought before the APA Ethical Committee between 1982 and 1986, 51% of the psychologists involved were found to have violated at least one ethical principle (APA Ethics Committee, 1988). Of the malpractice suits taken to court, 70% were settled in the psychologist's favor. Legal fees for malpractice suits that never reach the courts cost as much as $50,000 (Roswell, 1989).

Table 2

Issues in Ethical Violations Reported to APA Ethics Committee in 1988, 1989, and 1990*

Formal Cases Opened

Type of Case	Number of Cases		
	1988	1989	1990
Cases adjudicated in other jurisdictions			
Conviction of a felony	3	5	6
Loss of license	13	8	12
Expulsion from state association	3	0	2
Other	0	7	3
Sexual intimacy with client, dual relationship, or exploitation and/or sexual harassment	23	22	32
Inappropriate professional practice			
Child custody abuses	9	8	4
Practicing outside area of competence	8	13	15
Inappropriate responses to crisis	2	0	0
Breach of confidentiality	7	3	1
Lack of follow-up or desertion of client	1	1	1
Testing abuse	2	6	4
Fraudulent insurance claims/absence of advance notice of fee structure	8	4	4
Failure to respect other professionals	1	1	0
Other	0	0	1

(table continues)

Formal Cases Opened

Type of Case	Number of Cases		
	1988	1989	1990
Inappropriate teaching, research, or administration			
Authorship controversies	1	0	0
Plagiarism	1	0	1
Lack of due-process firing or lack of adequate supervision	1	0	1
Discrimination	1	0	0
Public statements			
Misuse of media	1	0	1
False, fraudulent, misleading statements	3	10	1
Public allegations about colleague	1	0	0
Failure to uphold standards of profession			
Response to ethics committee	0	0	0
Adherence to standards	0	1	1
Other	0	0	1
Total	89	91	92

* Adapted from Report of the APA ethics committee 1988, 1989, and 1990

The APA Ethics Committee (1988) identified dual relationships, inappropriate professional practice, and breaking confidentiality as the three most common areas of reported ethical violations.

Studies on the General Ethical Behaviors of Psychologists

Professional journals in all helping disciplines devote space to the discussion of professional ethics. A computer-based and manual literature search of professional journals in the helping disciplines revealed that for the past five years well over 5000 articles have been written on the subject of ethics, yet only a handful of the articles report actual studies on the ethical beliefs and practices of health-care professions and only two studies are available on the general ethical beliefs of health-care professionals. The rest of the articles promote the personal beliefs of individuals or small groups of health-care professionals rather than normative data on what the majority believes. When the computer search was narrowed to the three most common areas of ethical violations reported by the APA ethics committee the results indicate that confidentiality issues are the most written about area in the mental health-care professions, while professional practice issues are the most written about in the medical health-care professions. Table 3 presents the number of professional articles found by the computer search in each area.

Pope, Tabachnick, and Keith-Spiegel (1987, 1988) conducted a survey to examine the ethical knowledge, beliefs, and behaviors of psychologists, who where members of Division 29 (psychotherapy) of the APA. The 456 respondents to this survey where asked to rate each of 83 behaviors on several five-point scales from never to always, relating to how ethical the behavior is, how often the behavior occurs in their practice, and whether the behavior was good or poor practice. Conte et al. (1989) conducted a study of the ethical beliefs of psychotherapists. The 101 therapists responding to this survey rated 103 behaviors on a five-point scale from "acceptable practice" to "grounds for malpractice." The results from these studies are given below along with the results of studies of specific ethical behaviors of health-care professionals.

Table 3

The Number of Professional Articles Written in the Areas of Confidentiality, Dual Relationships, and Professional Practice for the Mental Health Professions and the Medical Professions

	Confidentiality		Dual Relationships		Professional Practice	
Year	Mental	Medical	Mental	Medical	Mental	Medical
1990	55	225	3	0	11	335
1989	67	346	3	0	25	305
1988	61	254	6	0	19	304
1987	74	225	0	1	19	237
1986	71	-	2	-	26	-
1985	99	-	0	-	22	-
1984	67	-	1	-	23	-
1983	48	-	1	-	23	-

Dual Relationships

The largest number of cases presented to the APA ethics committee in which an ethical violation is found, involve dual relationships (APA Ethics Committee, 1988). Dual relationships occur when the psychologist is involved in more than one type of relationship with a client, student, or employee at one time. Examples of this type of relationship are: providing therapy to

a student or employee or one of their family members, entering into business with a client, and/or sexual intimacies with clients.

Sexual intimacy with clients is the most costly form of a dual relationship (APA Ethics Committee, 1988; Roswell, 1989). Claims for legal settlements involving sexual intimacies with clients, between 1976 and 1986, total about 45% of the $15,653,376 paid out by APA's insurance provider. Psychologists engaging in sexual intimacies with clients and students are a much written about topic (APA Ethics Committee, 1988; Bernard & Jara, 1986; Bernard et al., 1987; Gabbard & Pope, 1988; Pope, 1987, 1988, 1989; Roswell, 1989; Striefel, 1989c). Since the 1979 revision of APA's ethical codes, the "Ethical Standards of Psychologists" (APA, 1979) has expressly forbidden sexual intimacies with clients, yet 2.6% of the psychologists responding to a survey by Pope et al. (1987) admitted that erotic activities have occurred with their clients and 1.9% admitted engaging in sexual contact with their clients. Another study by Pope and Bouhoutsos (1986) reported that 8.3% of surveyed male psychologists and 1.7% of surveyed female psychologists admitted engaging in therapist-client sex.

Therapist-client sexual intimacies are not limited to adult clients. Bajt and Pope (1989) found that 24% of the therapists surveyed had been involved in, or knew of incidents of therapist-client sexual intimacies involving minor clients. Other areas of dual relationships within psychology are less studied.

Borys and Pope (1989) conducted a survey of 4800 psychologists, psychiatrists, and social workers on therapist-client dual relationships regarding their beliefs and behaviors concerning dual relationships. They found that psychologists, psychiatrists and social workers did not differ in their ethical behaviors in terms of sexual intimacies, social involvements, financial involvements or other nonsexual dual relationships with their clients. Conte et al. support these results in their 1989 study.

Dual relationships are an area of ethical concern for psychotherapists of all disciplines (Borys & Pope, 1989; Conte et al., 1989); yet from the literature search on professional ethics,

dual relationships do not seem to be an area of ethical concern with health-care professionals outside the mental health-care professions since dual relationships are not mentioned in their professional literature.

Inappropriate Professional Practice

Inappropriate professional practice includes the violation of client's rights and failure to adhere to professional and legal standards and guidelines (APA Ethics Committee, 1988). According to the APA Ethics Committee (1988), inappropriate professional practice is the second most common problem area for reported ethical infractions for psychologists. These violations include such behavior's as failure to inform client's about the therapeutic process, not providing the agreed upon services, changing dates on service statements, billing insurance carriers for missed sessions, changing diagnoses for insurance purposes, and providing services for which one is not qualified.

In every article on client's rights or avoiding legal liability, regardless of the discipline, the use of informed consent procedures is stressed (Bruckner, 1987; Fowler, 1989; Jensen, Josephson, & Frey, 1989; Magistro, 1989; Novack et al., 1989; Roswell, 1989; Sheldon-Wildgen, 1982), yet data on the use of informed consent procedures among health-care professionals is missing from studies of ethical behaviors.

Pope et al. (1987) addressed informed consent issues once treatment had begun with questionnaire items such as letting the client see their charts and test results, but they did not address the issue of informing the client about treatment alternatives and the consequences before beginning treatment. Conte et al. (1989) did not even mention informed consent in their study.

Informed consent is informing clients and research participants of the nature and course of treatment or research, in such a way that they can understand the potential hazards and benefits of participation in the treatment or research, any alternative treatments, and their rights if they decide to participate in the treatment or research. It is a process whereby clients or research

participants are able to make an informed and rational decision about whether they want to continue with the treatment or research.

Ethical dilemmas arise with the issue of informed consent most often when working with minors and people with mental disabilities. For example, how old do clients have to be before they can make an informed decision about the course of treatment they will receive? If clients are unable to make an informed decision, who decides whether the treatment will continue?

Confidentiality

Confidentiality is:

> ... a concept which protects a client from unauthorized disclosures of information given (in confidence) without the client's consent. Confidentiality refers to an ethical practice, not a legal right. It is the responsibility which belongs to the psychologist (Roswell, 1989, p. 168).

The limits of confidentiality are defined as the extent to which information gained during evaluations and treatment can be shared with third parties (i.e., other staff, outside agencies, courts, parents, etc.). Legal codes and laws often mandate the limits placed on the rights of confidentiality between health-care professionals and their clients (Striefel, 1989a). In most states child abuse must be reported to the proper authorities, regardless of the relationship between client and therapist. Since the California Supreme Court decision in the case of Tarasoff versus Regents of the University of California many states have legally mandated that psychotherapists must report to the proper authorities, threatened violence by the client to self or others.

Conte et al. (1989) and Pope et al. (1987) reported a wide range of responses on items dealing with confidentiality. Approximately 60% of the respondents from these studies believe that breaking confidentiality is justified in every circumstance if the client is suicidal and approximately 70% believe breaking confidentiality is justified in every circumstance if the client is homicidal. On the other hand only 44% of the respondents from Conte et al. rated talking to family members about a client as unethical and 94% of the respondents from Pope et al. rated discussing clients by name with friends as always unethical.

Confidentiality is also an issue with health-care professionals outside the mental health field. Medical personnel must decide how much the family of a patient needs to know (Aroskar, 1989; Novack et al., 1989). The issue of confidentiality is a controversial issue when it come to the treatment of socially disapproved diseases such as AIDS and terminal diseases such as cancer (Aroskar, 1989; Morrison, 1989).

Ethical Knowledge and Ethical Behavior

Does knowledge of ethical principles translate into ethical behavior? Several studies have been conducted to try to answer this question. Bernard and Jara (1986) surveyed clinical psychology graduate students to see if they understood appropriate ethical behaviors and to see if they would report the unethical behaviors of their peers. Two scenarios of ethical misconduct (one involving a therapist with an alcohol problem and the other involving sexual misconduct with a client) were presented and the students were asked: a) if they knew what they should do and b) if they would take the appropriate action. The majority of the students knew their ethical responsibility, yet in response to both scenarios, approximately 50% of the students admitted they would probably not take any action. Bernard et al. (1987) repeated the study with professional psychology clinicians. In this study 25% of the clinicians admitted that they would do less than they knew they should when the behavior involved alcohol and 37% said they would do less than they should when the behavior involved sexual intimacies with a client. Wilkins, McGuire, Abbott, and Blau (1990) supported the results of Bernard's studies with a survey of 272 psychologists.

Pope and Bajt (1988) conducted a survey of 100 psychologists, "presumably knowledgeable and scrupulous regarding professional accountability." Sixty surveys were returned and of these, 57% of the respondents admitted to intentionally breaking a law or formal ethical principle. Pope and Bajt (1988) report:

> ...that three fourths of this select sample believed that psychologists should sometimes violate formal legal and ethical standards, and that a majority have actually done so, it is

> regrettable that only 18% report that the topic of conflicts between deeply held values and formal legal or ethical obligations was adequately addressed in their education, training, and supervision, and only 22% believe that the topic is addressed adequately in the professional literature. (p. 828)

Ansell and Ross (1990) defend the results of the study by Pope and Bajt (1988), yet disagree with their conclusions that the established ethical and legal standards are being eroded through intentional violation:

> Pope and Bajt should not be surprised at the responses of experienced, ethical psychologists ... It was clear to us that the '100 senior psychologists' chose their client's welfare over mindless obedience to reporting laws. (p. 399)

Ansell and Ross argued that reporting laws do not always protect the welfare of the children involved. Since the therapist's first concern should be the welfare of the child, it is no wonder that so many knowledgeable professionals have knowingly violated reporting laws.

A study of 749 senior nursing students revealed that 78% were able to identify the moral aspects of nursing and 72% reported being involved in resolving ethical conflicts in practice, yet only 40% made a conscious effort to apply ethical principles and only 23% used an ethical framework to help them resolve their ethical dilemmas (Gaul, 1989). Although the willingness of other health-care professionals to apply their ethical principles has not been studied, it would seem that there is gap between the level of professional knowledge of ethical principles and professionals' willingness to apply those principles as they understand them.

Benefits of Knowing the Normal Ethical Behaviors and Beliefs of Psychologists and Other Health-Care Professionals

Data on the moral beliefs and behaviors of health-care professionals is important in providing psychologists and other health-care professionals with the information they need in making responsible choices when faced with ethical dilemmas:

> The lack of comprehensive normative data about the behaviors of psychologists and their relationship to ethical standards leaves psychologists without adequate guidelines to inform their choices. (Pope et al., 1987, p. 1004)

By knowing the ethical beliefs and practices of other health-care professionals it is possible for individual professionals and ethics committees to make better informed decisions when faced with ethical dilemmas. Another benefit of data on ethical beliefs and practices is that those developing training programs and continuing education experiences will be better able to design their ethical curriculum to prepare their students to meet the ethical needs and demands of those whom they will serve.

Ethical codes that are confusing and misunderstood could be identified by gathering data on the beliefs and practices of psychologists and other health-care professionals. Once identified these problematic codes could be rewritten or education materials could be prepared to clarify their meanings and to educate health-care professionals on the importance of adherence to the principles.

Licensure and certification standards are designed to offer a first line of defense for protecting the welfare of the consumer from incompetent health-care professionals. If the problem areas in ethical beliefs and practices are identified, then licensure and certification procedures could be modified to insure that those applying for certification or licensure understand the ethical issues around the problem area.

For various reasons, psychologists are beginning to move their practices into hospital settings. As a result, health-care professionals from differing disciplines are more often working together in the same setting and on interdisciplinary treatment teams. As psychologists work with health-care professionals from other disciplines, it is necessary to gain an understanding of the ethical beliefs of each discipline so the differences between beliefs can be resolved (Pope, 1990).

Criticisms of the Studies of Ethical Beliefs and Behaviors

Koltko (1989) criticizes the study by Pope et al. (1987), saying that the use of five-point scales without specifically defining what each point means is too vague and leaves no replicable results. For example, Pope et al. used the terms "rarely, sometimes, fairly often, and very often"

to label each point of the scale while leaving it up to the respondent to determine what rarely means. Koltko suggests that those trying to replicate this study define the terms used in the scale, such as: "(1) never; (2) rarely (i.e., once or twice ever); (3) sometimes (i.e., more frequently than rarely, up to twice a year) ..." (p. 845). Pope, Tabachnick and Keith-Spiegel (1989) replied to Koltko's criticism by pointing out that "Particularly when some behaviors have low base rates, ipsative measurements prove useful in creating distributions that are less severely skewed" (p. 846). Pope et al. (1989) also pointed out that there are problems in the way that the frequencies are counted (i.e., six instances of a behavior in the last month for the psychologist that has been in practice for 10 years is less than one a year and could be coded as "rarely" thus not giving any information about the actual behavior).

All the authors of the studies presented here (Bernard et al., 1987; Bernard & Jara, 1986; Borys & Pope, 1989; Conte et al., 1989; Pope & Bajt, 1988; Pope et al., 1987) agree that their data is limited by the sample and the population that they studied and that further studies need to be conducted on different samples and populations. They also agree that survey data may not be the most reliable; but until better ways of monitoring the ethical practices of psychologists are developed, it is the only practical way to collect the needed information.

Summary

Ethics is the study of moral behavior and beliefs. Ethics in the health-care professions has come to mean intellectual discussions about what ought to be, while ignoring the actual behavior of professionals. As a result, health-care professions are in a state of crisis with the cost of insurance rising dramatically as the number of malpractice suits continues to increase. Ethical codes are changed not by an understanding of moral principles and the way those principles are applied but by public and legal pressure. An understanding of the beliefs and behaviors of practicing psychologists and other health-care professionals would be useful in helping the

profession of psychology control its own future rather than having others dictate what can and cannot be done.

The proposed study is a step in the continuing process of striving to understanding the ethical beliefs and behaviors of psychologists and how they compare to other health-care professionals. An understanding which is necessary to begin to allow ethics committees to be proactive to the needs of health-care professionals, their professions, and the individuals they serve, instead of reactive to the demands of society, government and the legal system.

CHAPTER III

PURPOSE AND OBJECTIVES

The general purpose of this study is to expand the available knowledge of the ethical beliefs and reported behaviors of psychologists and how these beliefs and reported behaviors compare to those of other health-care professions by surveying the membership of the Association for Applied Psychophysiology and Biofeedback (AAPB). It should be noted that all members of AAPB are expected to adhere to a common set of ethical principles which were developed based on those of APA (with APA's permission). This is an exploratory study, and there is a lack of sufficient data in the literature to make reasonable hypotheses about the ethical beliefs and behaviors of this population. The following research questions will serve to guide this study.

First, what are the ethical beliefs and behaviors of the members of AAPB? This question was answered by using descriptive statistics to give an overall picture of the ethical beliefs and reported practices of the respondents to the survey. Second, how do the ethical beliefs and reported practices of psychologists who belong to the AAPB compare to the ethical beliefs and reported practices of professionals and paraprofessionals of other health-care professions who are also members of the AAPB. Finally, what difference, if any, do educational experience, licensure and certification, age, years in practice, and gender have on ethical beliefs and behaviors?

CHAPTER IV

METHODS

Subjects

The subjects for this study were the 2048 members of the Association for Applied Psychophysiology and Biofeedback (AAPB) residing in the United States of America. The membership of AAPB offers a unique opportunity to compare the ethical behaviors and beliefs of psychologists to those of other health-care professionals and paraprofessionals, in that membership of the AAPB is made up of both professionals and paraprofessionals from a number of disciplines within the health-care professions. All members of AAPB are governed by a set of ethical principles and codes that are modeled after the ethical principles for the American Psychological Association. This condition offers the opportunity to explore differences in personal ethical beliefs and reported practices while holding differences in ethical principles constant. As can be seen from Table 4, 57% of the members of this organization are aligned with psychology while the remaining 43% are from various other health-care professions that use biofeedback as a treatment technique.

Borg and Gall (1989) suggest that for survey research there be at least 100 subjects in the major subgroup and 20 to 50 in each minor subgroup. The group of major interest for this study is "psychologists" with the other professionals being combined to form the second group. These groups were further subdivided based on the highest educational degree held by each member, whether they are licensed in their discipline and/or certified in biofeedback, the respondents' age, gender, and years in practice. To ensure that there were enough subjects in each cell, all members of the AAPB residing in the United States were sent a survey. Because of the nature of the questions being asked (i.e., Do you engage in erotic activity with your clients?) it was important that the survey be viewed as truly anonymous; therefore only one mailing of the survey was sent to each subject, and no personal identifiers were collected.

Table 4

Membership of the AAPB by Discipline

Discipline	%*	Number
Psychology	56.9	1143
Dental	0.5	10
Medical	7.0	141
Physical Therapy	3.5	70
Occupational Therapy	1.8	36
Chiropractic	0.4	7
Nursing	7.9	157
Social Work	5.8	115
Counseling	8.2	164
Education	2.1	42
Speech Pathology	0.6	12
Other	1.6	31

* Based on AAPB's data base as of 9/1/91, N = 1928

Of the three major surveys on ethical behavior conducted in this fashion, the response rate was between 45.6% and 50% (Borys & Pope, 1989; Conte et al., 1989; Pope et al., 1987). Using a conservative estimate of a 40% response rate, 880 members of the AAPB, or approximately 40% or more of the total population, were expected to respond. The demographic

information from the respondents was compared to the demographic make up of all members of AAPB as one measure of how well the responses generalized to the population as a whole.

Procedures

The thesis proposal was sent to the Utah State University Human Subjects Committee for approval. Due to the anonymous survey method being employed, it was the policy of the committee that the study receive automatic approval without a formal committee meeting. The proposal was then defended before a formal thesis committee. After approval by the thesis committee, every member of the Association for Applied Psychophysiology and Biofeedback (AAPB) residing in the United States was sent an ethics questionnaire. Addresses were obtained by using the 1990 mailing list for the Biofeedback Newsletter. The Biofeedback Newsletter is sent to every member of the AAPB.

All subjects were sent a cover letter, a copy of the survey (see appendix A), and a self-addressed stamped return envelope. It was assumed that by returning the completed survey, the subjects freely volunteered to participate in the study. No personal identifiers were requested from the subjects at any time.

Measures

The survey questionnaire was divided into two parts. First, the subjects were asked to give the following demographic information: discipline, education level, professional or paraprofessional status, certification and licenses held, years of practice in major discipline, years of practice in biofeedback, primary work setting, age, and sex. Each subject who responded to the survey was placed in a group based on their professional affiliation, education level, licensure status, certification status, age, gender, and years in practice. The rest of the demographic information was used to compare the respondents to the population of AAPB members as a whole.

The second part of the questionnaire consisted of a descriptive list of 99 behaviors. This list was adapted, with the permission of Dr. Pope, from the questionnaire used by Pope et al. in their 1987 study. Some items were changed to clarify the content of the questions with which subjects had difficulty and new items were added to make the questionnaire appropriate for the population being surveyed (see appendix A). The subjects were asked to rate each behavior on two scales. First, how ethical do they consider the behavior. Subjects had five categories to choose from: a) never ethical, b) rarely ethical, c) don't know/not sure, d) often ethical, e) always ethical. Second, the subjects were asked to rate how often the behavior occurs in their practice. The subjects rated the occurrence of the behavior in their practice on a five point scale: a) never occurs, b) rarely occurs, c) sometimes occurs, d) occurs fairly often, e) occurs very often.

Each item on the questionnaire was placed into one of three scales based on the content on the item: a) behaviors dealing with dual relationships, b) behaviors dealing with professional practice, and c) behaviors dealing with confidentiality (see appendix B). Each completed questionnaire received six scores; one for each of the three content scales, rated on how ethical the respondents believed the behavior to be, and one for each of the content scales rated for how often the behavior occurred in the respondents' practices. These scores were obtained by adding the numeric value of the responses for each item in each of the six scales described above.

CHAPTER V

RESULTS

This was an initial study comparing the reported ethical beliefs and behaviors of psychologists, who use biofeedback interventions, to other health-care professionals, who also use biofeedback interventions. It was expected that due to the heterogeneity of the health-care professions that there would be statistically significant differences between the reported ethical beliefs and practices of the health-care professionals surveyed. Due to the lack of available research in this area it was impossible to make non-biased statements about possible outcomes; hence for statistical purposes, it was assumed that there should be no differences. The statistical null hypothesis used for these comparisons is that there is no difference between psychologists and other health-care professionals in their reported ethical beliefs and practices regardless of their educational level, licensure or certification status, age, years in practice, or gender.

Demographic Characteristics

Five hundred forty-five or 26.6% of the 2048 questionnaires sent out were returned. Of the 545 returned questionnaires 9 had less than half the survey items completed and were not used in any analysis, leaving 536 questionnaires to be used for analysis. Demographic characteristics of the respondents in terms of sex, age, education level, discipline, primary work setting, licensure status, BCIA certification status, number of years in professional practice, and number of years practicing biofeedback compared to the total AAPB memberships are presented in Table 5. Demographic information for the total population was obtained from AAPB's data base as of September 1, 1991 based on a total of 1996 members who provided demographic information.

Table 5

Demographic Characteristics of AAPB Members Providing Usable Data Compared to Total AAPB Membership

Characteristic	Category	Respondents N	Respondents %*	AAPB Members %*
Sex	Male	274	51.1	NA***
	Female	258	48.3	NA
	No Response	3	.6	NA
Age Group	45 and under	282	52.6	NA
	Over 45	236	44.0	NA
	No Response	18	3.4	NA
Education Level	Ph.D. Equivalent	247	46.1	53.0
	M.S. Equivalent	198	36.9	30.6
	B.S. Equivalent	74	13.8	14.5
	Less than B.S.	10	1.9	2.0
	No Response	7	1.3	0.0
Primary Work Setting	Private Practice	236	44.0	62.1
	Hospital/Inst.	122	22.8	17.7
	University/Acad.	57	10.6	NA
	Clinic	53	9.9	16.2
	Grade School	5	0.9	NA
	Multiple Settings	31	5.8	NA
	No Response	5	0.9	4.0

(table continues)

		Respondents		AAPB Members
Characteristic	Category	N	%*	%*
Discipline	Psychology	305	56.9	57.3
	Counseling	55	10.3	8.2
	Nursing	46	8.6	7.9
	Social Workers	19	3.5	5.8
	Physical Therapy	18	3.4	3.5
	Medical Doctors	16	3.0	7.0
	Education	14	2.6	2.1
	Occupational Therapy	9	1.7	1.8
	Speech Pathology	5	0.9	0.6
	Dental	1	0.2	0.5
	Chiropractic	1	0.2	0.4
	Other	31	5.8	1.6
	No Response	16	3.0	3.4
Licensed	Yes	378	70.5	63.7
	No	141	26.3	23.5
	No Response	17	3.2	12.8
BCIA Certified	Yes	306	57.1	49.4
	No	203	37.9	50.5
	No Response	27	5.0	NA

(table continues)

Characteristic	Category	Respondents N	Respondents %*	AAPB Members %*
Licensed & Certified	Yes	209	38.9	NA
Years in Professional Practice	0 - 5	88	16.4	NA
	6 - 10	98	18.3	NA
	11 - 15	114	21.2	NA
	16 - 20	100	18.7	NA
	Over 20	111	20.7	NA
	No Response	25	4.6	NA
Years Practicing Biofeedback	0 - 5	163	30.4	30.0
	6 - 10	172	32.1	31.1
	11 - 15	121	22.6	31.0
	16 - 20	61	11.4	7.5
	Over 20	8	1.5	0.7
	No Response	11	2.1	1.7

* Percentages may not add to 100 due to rounding

** Based on AAPB's data base as of 9/1/91, N = 1996

*** Data not available

Ratings of the 99 Behaviors

The first question to be answered is: What are the reported ethical beliefs and practices of the members of the AAPB. To answer this question, the survey results are listed, giving the percentage of respondents reporting under each category, for each item.

Table 6 presents the percentage of respondents' ratings in terms of the ethicalness of individual survey items. Table 7 presents the percentage of respondents' ratings in terms of the frequency of occurrence of the behavior in the respondent's practice. Figure 1 presents the percentage of respondents who responded "never" or "rarely" ethical, "often" or "always" ethical, or "don't know," and "never" or "rarely" occurs, "often" or "always" occurs, or "sometimes" occurs to the questions dealing with confidentiality. Figure 2 presents the percentage of respondents who responded "never" or "rarely" ethical, "often" or "always" ethical, or "don't know," and "never" or "rarely" occurs, "often" or "always" occurs, or "sometimes" occurs to the questions dealing with dual relationship. Figure 3 presents the percentage of respondents who responded "never" or "rarely" ethical, "often" or "always" ethical, or "don't know," and "never" or "rarely" occurs, "often" or "always" occurs, or "sometimes" occurs to the questions dealing with professional practice. Items in figures 1, 2, and 3 are arranged from the item with the highest rating in the "never/rarely" category to the items with the highest rating in the "often/always" category.

Behaviors Universally Accepted as Ethical

Pope et al. (1987) defined "universally accepted behaviors" as those behaviors that occurred rarely for at least 90% of the respondents. This definition is problematic in that a behavior that has occurred once in 20 years of practice does not indicate that the behavior is universally accepted or practiced. For this survey a stricter definition is used to define universally accepted and practiced behaviors. Universally accepted is defined as those behaviors where at least 85% of the respondents report that the behavior is "often" or "always" ethical. Universally

Table 6

Percentage of Respondents Who Responded in each Category to the Question "How Ethical is this Behavior?"

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
1. Becoming social friends with a former client.	13.1	40.9	18.5	20.9	6.5	0.2
2. Charging a client no fee for therapy.	6.3	19.6	18.1	31.0	24.4	0.6
3. Providing therapy to one of your friends.	33.8	30.6	10.4	16.4	7.8	0.9
4. Advertising in newspapers or similar media.	6.7	10.1	13.6	37.9	31.3	0.4
5. Limiting treatment notes to name, date, and fee.	48.5	22.8	14.6	6.7	5.8	1.7
6. Filing an ethics complaint against a colleague.	2.4	5.8	6.9	40.9	42.2	1.9
7. Telling a client you are angry at him or her.	10.1	23.1	15.3	36.9	13.8	0.7
8. Using a computerized testing service.	1.1	4.3	19.8	36.6	35.8	2.4
9. Hugging a client.	3.5	19.2	15.7	48.3	11.8	1.5
10. Terminating therapy if the client cannot pay.	17.7	24.6	17.9	28.5	10.6	0.6
11. Accepting services from a client is lieu of fee.	36.2	20.1	19.2	17.2	6.3	0.9

(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
12. Seeing a minor client without parental consent.	43.7	23.3	13.1	13.1	5.0	1.9
13. Having clients take tests (e.g., MMPI) at home.	28.4	19.8	24.3	19.2	6.3	2.1
14. Altering a diagnosis to meet insurance criteria.	48.1	25.7	14.2	9.3	2.1	0.6
15. Telling client: "I'm sexually attracted to you."	70.9	17.4	5.6	3.5	2.2	0.4
16. Refusing to let clients read their chart notes.	26.1	28.2	16.2	20.1	9.0	0.4
17. Using a collection agency to collect late fees.	3.4	7.1	17.5	38.6	32.1	1.3
18. Breaking confidentiality if the client is homicidal.	2.8	2.6	6.7	17.4	69.2	1.3
19. Performing forensic work for a contingency fee.	21.8	7.6	42.9	10.3	12.7	4.7
20. Using self-disclosure as a therapy technique.	3.4	9.1	14.7	51.9	19.4	1.5
21. Inviting clients to an office open house.	21.5	17.4	25.2	19.2	14.6	2.2
22. Accepting a client's gift worth at least $50.	37.1	28.7	18.3	9.3	6.0	0.6
23. Working when to distressed to be effective.	49.1	35.3	9.9	3.0	2.4	0.4

(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
24. Accepting only male or female clients.	21.6	12.9	23.3	21.3	18.8	2.1
25. Not allowing clients access to testing report.	29.5	31.3	13.2	19.4	5.2	1.3
26. Rasing the fee during the course of therapy.	24.6	20.3	13.6	27.2	12.7	1.5
27. Breaking confidentiality if the client is suicidal.	2.2	3.2	5.0	23.9	64.2	1.5
28. Not allowing clients access to raw test data.	16.8	14.0	17.9	20.5	28.7	2.1
29. Allowing clients to run up a large unpaid bill.	12.1	30.4	29.7	19.4	6.7	1.7
30. Accepting goods (rather than money) as payment.	25.7	19.0	23.1	20.0	9.7	2.4
31. Refusal to treat clients with AIDS.	48.5	25.9	11.2	6.5	7.1	0.7
32. Breaking confidentiality to report child abuse.	2.8	2.4	4.5	19.0	70.3	0.9
33. Inviting clients to a party or social event.	47.8	31.0	11.2	5.0	2.6	2.4
34. Addressing the client by his or her first name.	1.7	1.3	2.6	43.5	50.4	0.6
35. Engaging in erotic activity with a client.	95.5	1.9	0.2	0.2	1.7	0.6
36. Using individualized treatment plans.	0.7	0.2	1.9	6.5	88.8	1.9

(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
37. Asking favors (e.g., a ride home) from clients.	30.6	44.8	13.6	7.6	3.0	0.4
38. Making custody evaluations without seeing the child.	67.4	15.7	9.9	2.1	1.9	3.2
39. Accepting the client's decision to commit suicide.	46.5	24.3	15.5	7.3	4.9	1.7
40. Refusing to disclose a diagnosis to a client.	33.2	38.1	12.9	12.3	2.2	1.3
41. Revising treatment plans regularly.	0.9	1.3	2.8	19.0	74.6	1.3
42. Telling clients of your disappointment in them.	19.0	34.5	15.1	21.3	8.0	2.1
43. Discussing clients (without names) with friends.	41.6	35.1	9.3	10.3	2.4	1.3
44. Providing therapy to your student or supervisee.	40.3	26.5	13.6	11.9	5.4	2.2
45. Giving gifts to those who refer clients to you.	39.9	20.0	17.9	13.8	6.2	2.2
46. Using a law suit to collect fees from clients.	10.4	15.3	29.1	27.1	16.0	2.1
47. Becoming sexually involved with a former client.	59.7	24.8	8.4	4.1	1.1	1.9
48. Avoiding certain clients for fear of being sued.	15.5	20.9	28.2	22.2	11.4	1.9

(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
49. Doing custody evaluations without seeing both parents.	54.3	22.8	13.6	3.4	1.7	4.3
50. Lending money to a client.	59.7	27.8	8.4	1.5	1.1	1.5
51. Providing therapy to one of your employees.	41.0	25.6	13.8	11.9	4.9	2.8
52. Having a client address you by your first name.	0.6	3.5	6.5	34.5	53.2	1.7
53. Sending holiday greeting cards to your clients.	7.6	9.1	23.3	27.6	30.6	1.7
54. Kissing a client.	65.5	22.0	4.9	4.3	1.3	2.1
55. Obtaining only verbal permission to treat client.	17.4	14.7	25.0	22.0	17.5	3.4
56. Giving a gift worth at least $50 to a client.	66.6	17.7	10.3	1.9	1.9	1.7
57. Accepting a client's invitation to a party.	37.9	35.8	14.2	7.5	3.0	1.7
58. Engaging is sex with a clinical supervisee.	88.4	6.0	2.4	0.9	0.9	1.3
59. Going to a client's special event (e.g., wedding).	9.3	25.2	22.6	29.1	12.1	1.7
60. Getting paid to refer clients to someone.	83.8	7.3	4.9	1.9	0.4	1.9
61. Going into business with a client.	66.6	17.1	11.4	1.5	1.3	1.5

(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
62. Engaging in sexual contact with a client.	97.0	1.1	0.0	0.2	0.4	1.3
63. Utilizing involuntary hospitalization.	5.6	9.3	17.4	42.0	21.8	3.9
64. Selling goods to a client.	51.9	17.0	11.2	13.6	4.1	2.2
65. Giving personal advise on radio, T.V., etc.	14.2	20.1	27.1	25.6	10.4	2.6
66. Being sexually attracted to client.	22.9	12.1	23.5	18.5	18.1	4.9
67. Unintentionally disclosing confidential information.	68.1	18.7	7.6	2.1	1.3	2.2
68. Allowing a client to disrobe in your presence.	71.8	13.4	5.0	6.0	1.1	2.6
69. Borrowing money from a client.	91.0	6.0	1.1	0.0	0.2	1.7
70. Discussing a client (by name) with friends.	97.0	1.3	0.2	0.0	0.2	1.3
71. Providing services outside areas of competence.	84.0	13.1	0.7	0.4	0.6	1.3
72. Signing for hours a supervisee has not earned.	93.7	3.5	0.0	0.2	0.4	2.2
73. Treating homosexuality per se as pathological.	57.5	15.1	17.5	4.5	2.8	2.6
74. Doing therapy whole under the influence of alcohol.	95.5	2.6	0.0	0.0	0.2	1.7
75. Engaging in sexual fantasy about a client.	39.2	14.2	22.0	11.4	9.3	3.9

(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
76. Accepting a gift worth less than $5 from a client.	9.0	12.7	15.3	42.0	19.6	1.5
77. Offering or accepting a handshake from a client.	1.3	0.9	2.1	15.5	78.2	2.1
78. Disrobing in the presence of a client.	97.0	0.4	0.4	0.0	0.7	1.5
79. Charging for missed appointments.	4.1	8.4	14.0	49.1	23.9	0.6
80. Going into business with a former client.	33.6	25.9	24.4	10.3	4.7	1.1
81. Directly soliciting a person to be a client.	44.4	26.1	15.7	10.1	2.8	0.9
82. Being sexually attracted to a client.	22.9	12.7	27.2	15.3	16.6	5.2
83. Helping a client file a complaint about a colleague.	12.9	10.3	24.3	34.1	16.8	1.7
84. Telling clients what they should do.	12.9	26.1	13.4	35.4	10.3	1.9
85. Explaining biofeedback process before treatment.	1.1	0.4	0.4	4.1	93.5	0.6
86. Continuing to see clients for treatment when treatment goals have been reached.	38.6	33.8	9.7	13.6	3.2	1.1
87. Continuing services to a client when the client is no longer receiving any benefits.	64.0	22.8	2.8	5.0	4.3	1.1

(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
88. Clearly defining criteria for determining whether client is benefiting from services.	1.7	0.7	2.1	14.2	80.6	0.7
89. Establishing individual contracts with clients for services.	3.5	2.2	10.6	20.3	61.9	1.3
90. Deceiving clients for their own good.	48.1	32.8	12.3	5.4	0.6	0.7
91. Using the same biofeedback instructions for all clients.	22.9	24.6	18.1	23.1	10.3	0.9
92. Dressing seductively for sessions with clients.	89.4	8.6	0.7	0.4	0.0	0.9
93. Paying undue attention to client's dress and appearance.	57.5	27.1	10.4	3.4	0.6	1.1
94. Crying in the presence of a client.	20.3	30.8	20.1	20.0	7.8	0.9
95. Consultation with colleagues on regular basis.	0.6	0.4	2.2	16.4	79.1	1.3
96. Using written informed consent procedures.	1.9	0.7	2.1	7.5	85.4	2.4
97. Terminating services to a client because you are sexually attracted to them.	4.1	7.5	7.5	26.7	47.9	1.1
98. Keeping updated on ethical principles and state laws that affect your practice of biofeedback.	1.7	0.2	0.6	3.2	93.7	0.7

(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
99. Discussing clients with other family members.	40.9	27.2	11.8	16.8	2.6	0.7

Table 7

Percentage of Respondents Who Responded in each Category to the Question "How Often does this Behavior Occur in your Practice?"

Behaviors	Never	Rarely	Sometimes	Often	Always	No Answer
1. Becoming social friends with a former client.	42.7	39.0	14.2	2.8	0.7	0.6
2. Charging a client no fee for therapy.	23.9	39.7	27.1	5.2	3.2	0.9
3. Providing therapy to one of your friends.	49.3	32.8	12.5	3.4	0.7	1.3
4. Advertising in newspapers or similar media.	47.2	17.0	16.4	10.8	6.7	1.9
5. Limiting treatment notes to name, date, and fee.	73.7	14.9	4.9	2.8	1.1	2.6
6. Filing an ethics complaint against a colleague.	72.0	22.0	2.2	0.9	0.6	2.2
7. Telling a client you are angry at him or her.	33.8	42.0	19.0	3.2	0.4	1.7
8. Using a computerized testing service.	39.0	15.1	17.4	14.0	10.6	3.9
9. Hugging a client.	9.5	41.2	29.5	13.2	4.5	2.1
10. Terminating therapy if the client cannot pay.	40.7	31.7	18.7	5.6	1.7	1.7
11. Accepting services from a client is lieu of fee.	73.7	17.5	5.4	1.3	0.0	2.1

(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
12. Seeing a minor client without parental consent.	81.0	11.6	3.9	0.6	0.2	2.8
13. Having clients take tests (e.g., MMPI) at home.	58.2	16.0	14.7	5.6	2.4	3.0
14. Altering a diagnosis to meet insurance criteria.	51.7	25.7	13.8	5.6	1.7	1.5
15. Telling client: "I'm sexually attracted to you."	90.3	7.5	0.7	0.4	0.2	0.9
16. Refusing to let clients read their chart notes.	52.6	25.7	9.9	5.2	4.5	2.1
17. Using a collection agency to collect late fees.	43.8	20.1	20.0	8.6	4.9	2.6
18. Breaking confidentiality if the client is homicidal.	54.5	24.4	9.9	2.8	6.2	2.2
19. Performing forensic work for a contingency fee.	80.6	4.9	4.5	1.3	1.7	7.1
20. Using self-disclosure as a therapy technique.	11.8	18.5	36.8	24.4	5.8	2.8
21. Inviting clients to an office open house.	69.2	14.2	9.1	3.0	1.7	2.8
22. Accepting a client's gift worth at least $50.	76.7	17.7	3.0	0.7	0.4	1.5
23. Working when too distressed to be effective.	54.1	33.4	8.4	2.4	0.4	1.3

(table continues)

	Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
24.	Accepting only male or female clients.	88.1	4.9	2.2	0.9	0.7	3.2
25.	Not allowing clients access to testing report.	58.2	22.4	8.0	6.5	2.2	2.6
26.	Raising the fee during the course of therapy.	50.2	25.2	17.2	3.9	1.1	2.4
27.	Breaking confidentiality if the client is suicidal.	26.5	30.2	24.6	6.5	9.7	2.4
28.	Not allowing clients access to raw test data.	56.0	14.4	7.6	7.3	11.6	3.2
29.	Allowing clients to run up a large unpaid bill.	30.6	34.7	24.6	6.2	0.6	3.4
30.	Accepting goods (rather than money) as payment.	76.5	16.0	3.0	0.7	0.2	3.5
31.	Refusal to treat clients with AIDS.	86.2	6.3	3.7	1.1	0.7	1.9
32.	Breaking confidentiality to report child abuse.	40.3	23.5	17.0	6.3	10.6	2.2
33.	Inviting clients to a party or social event.	78.2	15.3	2.6	0.7	0.2	3.0
34.	Addressing the client by his or her first name.	1.3	2.6	6.7	29.3	58.6	1.5
35.	Engaging in erotic activity with a client.	95.0	2.1	0.6	0.2	0.6	1.7
36.	Using individualized treatment plans.	0.9	1.7	2.6	11.9	80.4	2.4

(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
37. Asking favors (e.g., a ride home) from clients.	72.0	23.9	2.2	0.4	0.2	1.3
38. Making custody evaluations without seeing the child.	87.1	5.8	1.7	0.2	0.7	4.5
39. Accepting the client's decision to commit suicide.	82.5	11.4	2.2	0.7	0.2	3.0
40. Refusing to disclose a diagnosis to a client.	61.2	24.8	8.2	2.4	1.1	2.2
41. Revising treatment plans regularly.	1.7	3.4	13.4	34.7	44.4	2.4
42. Telling clients of your disappointment in them.	38.6	37.5	13.1	6.3	1.5	3.0
43. Discussing clients (without names) with friends.	34.1	42.2	14.6	4.7	2.2	2.2
44. Providing therapy to your student or supervisee.	69.4	16.6	6.9	3.0	0.6	3.5
45. Giving gifts to those who refer clients to you.	65.9	16.0	9.3	4.5	1.5	2.8
46. Using a law suit to collect fees from clients.	74.1	14.7	5.2	1.7	0.7	3.5
47. Becoming sexually involved with a former client.	91.0	4.5	1.1	0.6	0.0	2.8
48. Avoiding certain clients for fear of being sued.	59.7	26.5	7.8	2.4	0.6	3.0

(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
49. Doing custody evaluations without seeing both parents.	80.8	10.6	2.2	0.2	0.0	6.2
50. Lending money to a client.	83.8	12.3	1.7	0.0	0.0	2.2
51. Providing therapy to one of your employees.	68.3	17.5	6.3	3.9	0.6	3.4
52. Having a client address you by your first name.	3.5	7.5	16.6	25.0	45.1	2.2
53. Sending holiday greeting cards to your clients.	53.9	14.6	11.9	8.8	8.0	2.8
54. Kissing a client.	83.6	10.3	2.8	0.4	0.4	2.6
55. Obtaining only verbal permission to treat client.	37.7	16.6	13.1	14.2	13.2	5.2
56. Giving a gift worth at least $50 to a client.	91.8	4.9	0.4	0.2	0.0	2.8
57. Accepting a client's invitation to a party.	71.8	20.9	3.7	0.7	0.2	2.6
58. Engaging is sex with a clinical supervisee.	94.4	2.4	0.9	0.2	0.0	2.1
59. Going to a client's special event (e.g., wedding).	45.5	35.1	12.9	2.6	1.1	2.8
60. Getting paid to refer clients to someone.	92.9	2.2	1.3	0.2	0.0	3.4
61. Going into business with a client.	92.0	4.3	0.9	0.2	0.0	2.6

(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
62. Engaging in sexual contact with a client.	95.5	1.9	0.4	0.2	0.0	2.1
63. Utilizing involuntary hospitalization.	47.6	27.4	12.9	5.0	1.9	5.2
64. Selling goods to a client.	70.9	13.8	7.6	3.5	1.1	3.0
65. Giving personal advise on radio, T.V., etc.	71.3	12.9	6.9	4.1	0.9	3.9
66. Being sexually attracted to client.	29.9	37.1	23.1	4.5	1.3	4.1
67. Unintentionally disclosing confidential information.	50.0	43.7	2.8	0.6	0.0	3.0
68. Allowing a client to disrobe in your presence.	83.0	7.6	2.8	1.9	0.9	3.7
69. Borrowing money from a client.	95.5	1.7	0.4	0.0	0.0	2.4
70. Discussing a client (by name) with friends.	92.9	4.1	0.4	0.4	0.0	2.2
71. Providing services outside areas of competence.	78.0	15.7	2.8	1.1	0.2	2.2
72. Signing for hours a supervisee has not earned.	90.1	5.2	0.7	0.9	0.0	3.0
73. Treating homosexuality per se as pathological.	82.3	6.7	5.0	1.7	0.4	3.9
74. Doing therapy whole under the influence of alcohol.	93.8	3.0	0.2	0.4	0.0	2.6
75. Engaging in sexual fantasy about a client.	49.1	32.1	12.3	1.7	0.6	4.3

(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
76. Accepting a gift worth less than $5 from a client.	14.0	42.0	31.2	7.6	2.6	2.6
77. Offering or accepting a handshake from a client.	0.7	1.3	7.1	22.2	65.7	3.0
78. Disrobing in the presence of a client.	95.0	1.5	0.4	0.2	0.6	2.4
79. Charging for missed appointments.	31.5	21.5	25.7	14.4	5.4	1.5
80. Going into business with a former client.	89.2	6.5	1.7	0.6	0.0	2.1
81. Directly soliciting a person to be a client.	70.7	17.9	6.7	2.2	0.4	2.1
82. Being sexually attracted to a client.	31.3	38.1	20.7	3.9	1.3	4.7
83. Helping a client file a complaint about a colleague.	72.2	21.1	2.8	0.7	0.6	2.6
84. Telling clients what they should do.	16.6	32.6	23.9	14.7	6.2	3.0
85. Explaining biofeedback process before treatment.	1.5	0.2	0.4	4.5	92.0	1.5
86. Continuing to see clients for treatment when treatment goals have been reached.	44.8	34.5	13.8	3.9	1.1	1.9
87. Continuing services to a client when the client is no longer receiving any benefits.	60.4	27.1	5.8	3.0	1.9	1.9

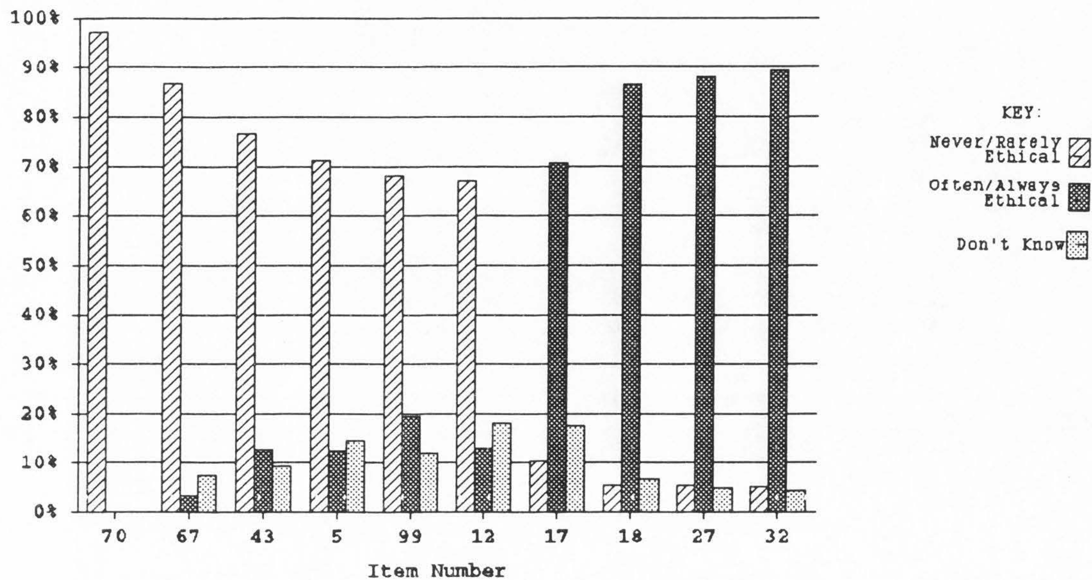
(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
88. Clearly defining criteria for determining whether client is benefiting from services.	1.7	2.8	9.0	34.9	50.0	1.7
89. Establishing individual contracts with clients for services.	16.8	9.5	18.7	21.1	30.4	3.5
90. Deceiving clients for their own good.	64.6	26.1	6.7	0.7	0.0	1.9
91. Using the same biofeedback instructions for all clients.	38.1	24.6	16.8	12.3	6.0	2.2
92. Dressing seductively for sessions with clients.	93.3	4.1	0.4	0.4	0.0	1.9
93. Paying undue attention to client's dress and appearance.	71.3	21.3	4.5	0.6	0.4	2.1
94. Crying in the presence of a client.	56.2	33.8	8.0	0.2	0.0	1.9
95. Consultation with colleagues on regular basis.	1.1	5.2	16.8	33.4	41.2	2.2
96. Using written informed consent procedures.	6.2	8.8	10.8	15.9	54.5	3.9
97. Terminating services to a client because you are sexually attracted to them.	71.1	17.4	5.2	1.3	2.2	2.8
98. Keeping updated on ethical principles and state laws that affect your practice of biofeedback.	1.9	1.7	9.3	28.9	56.5	1.7

(table continues)

Behaviors	Never	Rarely	Don't Know	Often	Always	No Answer
99. Discussing clients with other family members.	33.2	37.3	17.2	9.0	1.5	1.9

How ethical is this behavior?



How often does this behavior occur in your practice?

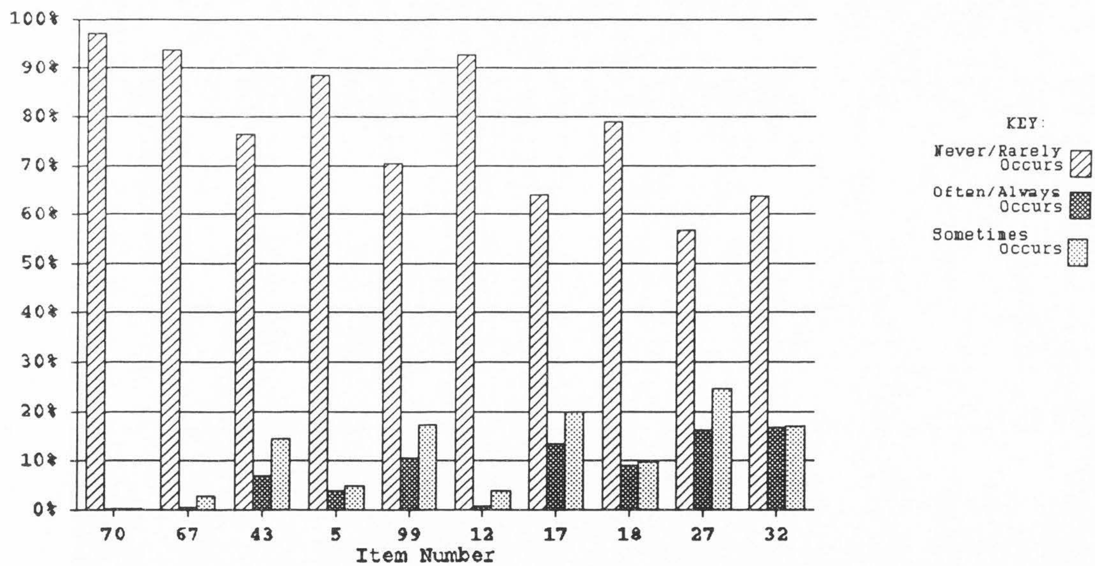
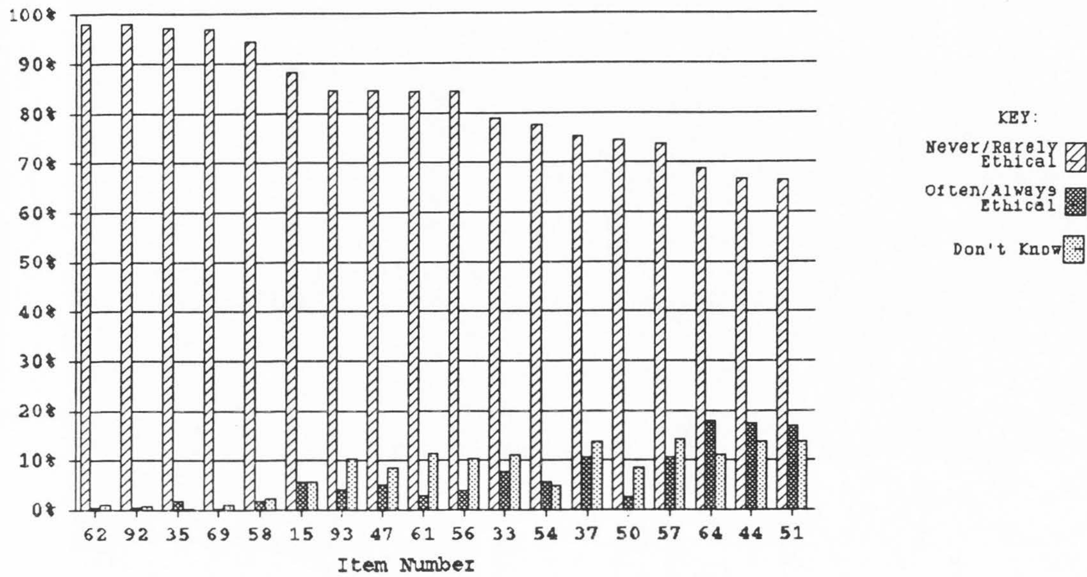


Figure 1. Percentage of responses to behavior items in each category from the confidentiality scale.

How ethical is this behavior?



How often does this behavior occur in your practice?

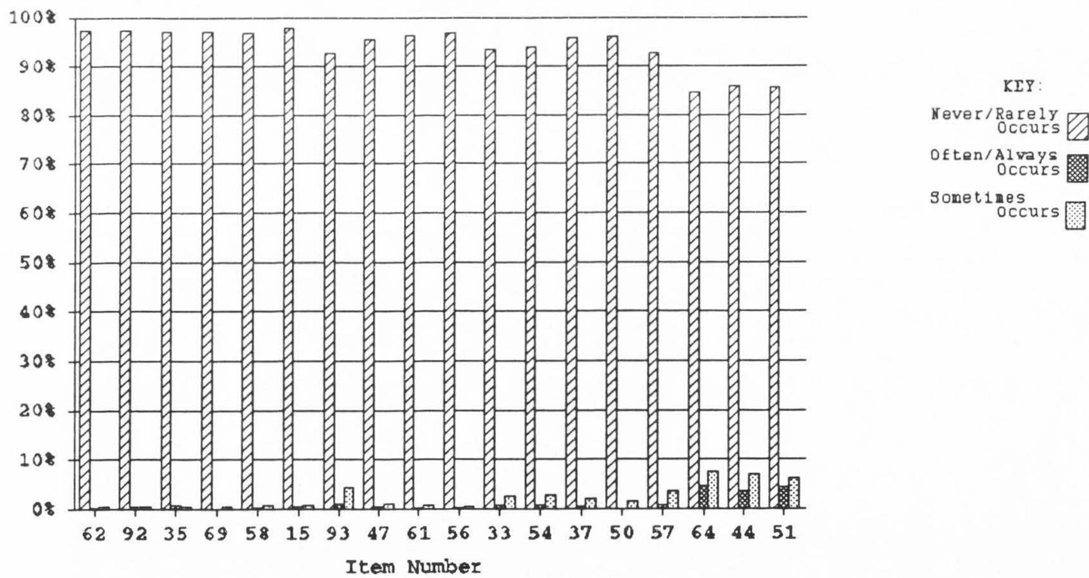
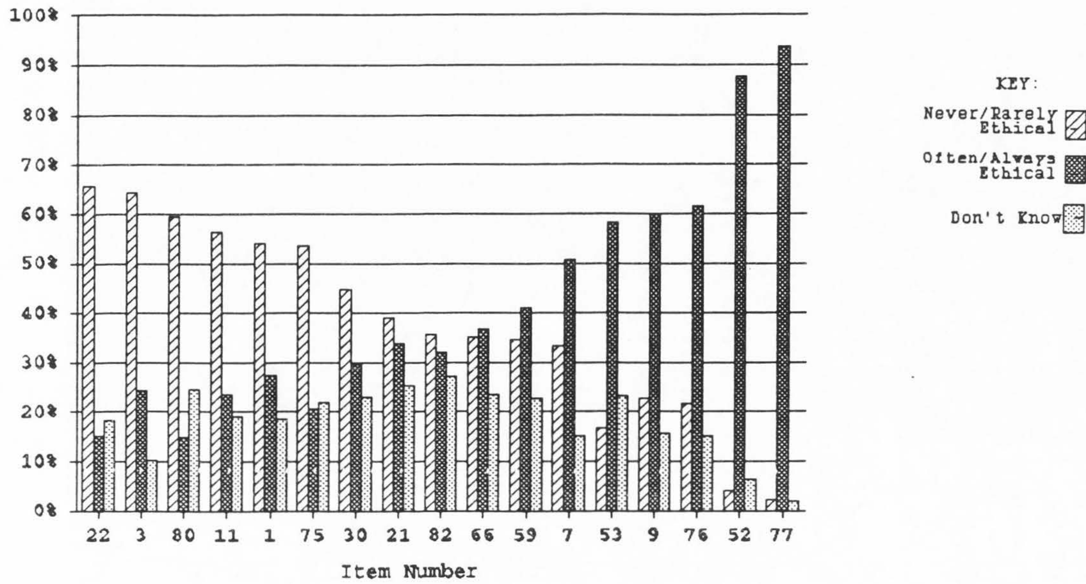


Figure 2. Percentage of responses to behavior items in each category from the dual relationship scale.

(figure continues)

How ethical is this behavior?



How often does this behavior occur in your practice?

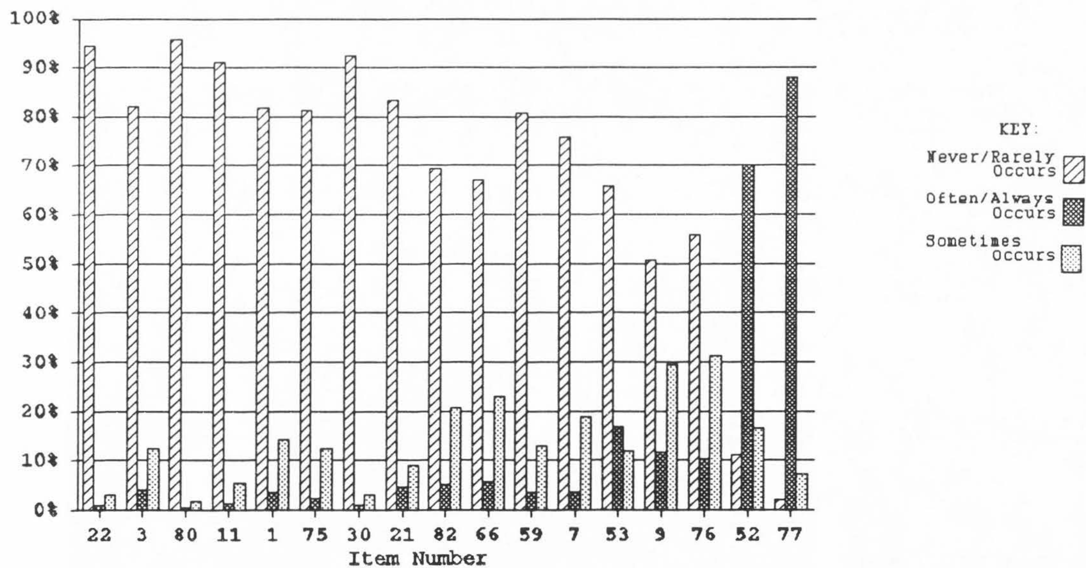
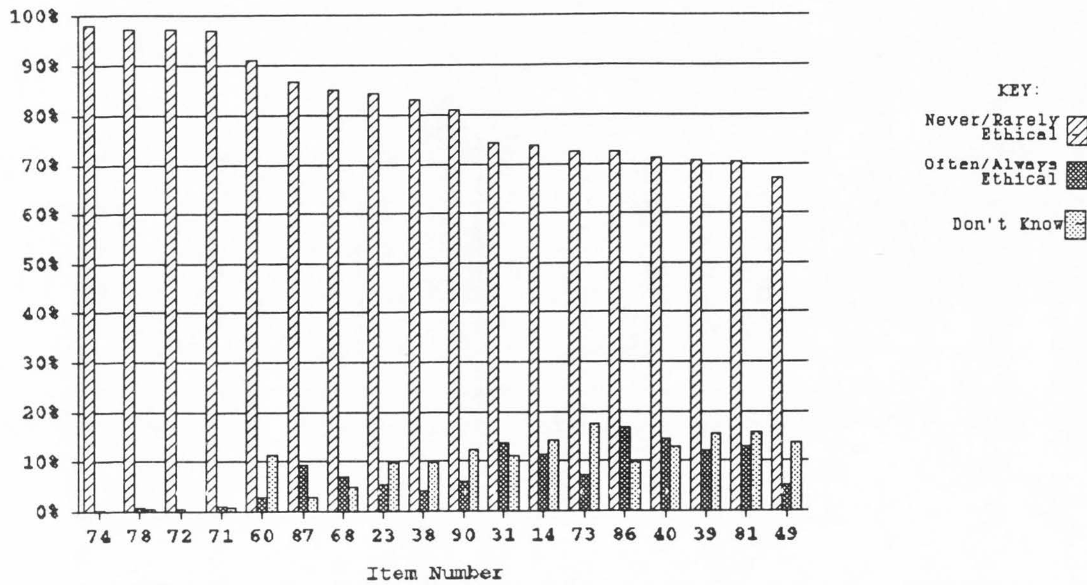


Figure 2. Percentage of responses to behavior items in each category from the dual relationship scale.

How ethical is this behavior?



How often does this behavior occur in your practice?

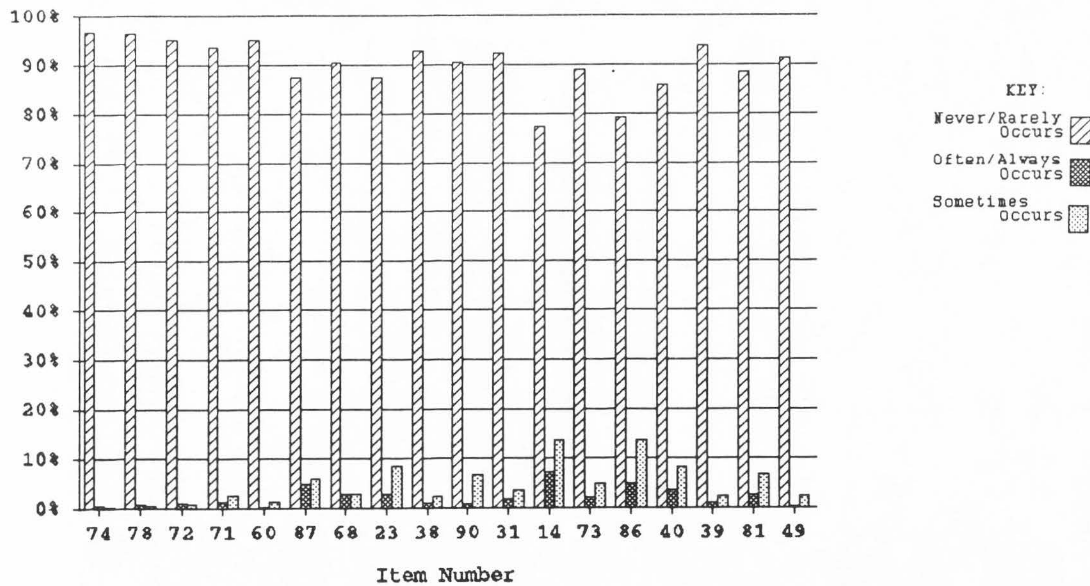
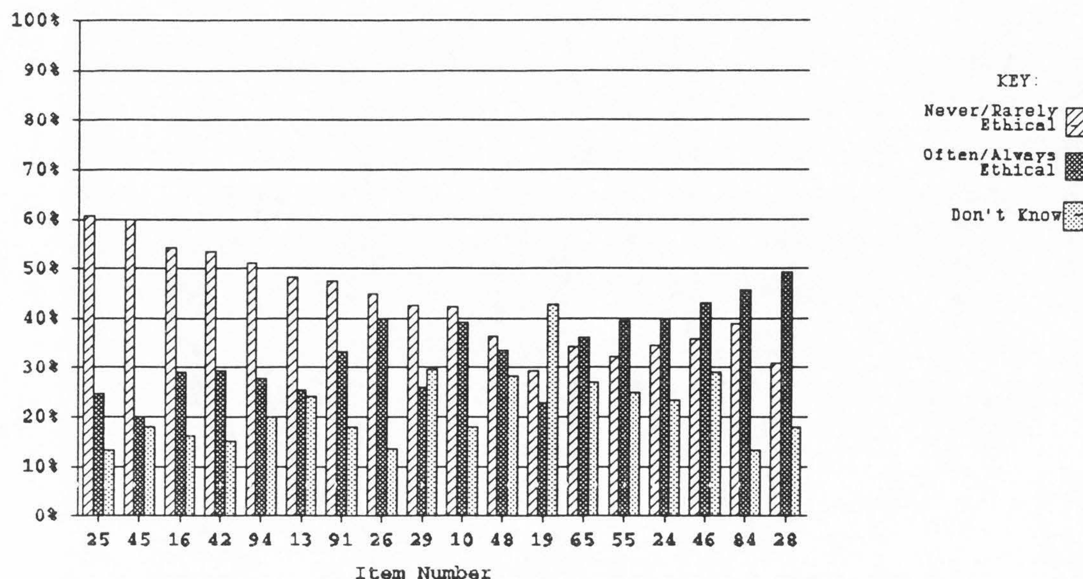


Figure 3. Percentage of responses to behavior items in each category from the professional practice scale.

(figure continues)

How ethical is this behavior?



How often does this behavior occur in your practice?

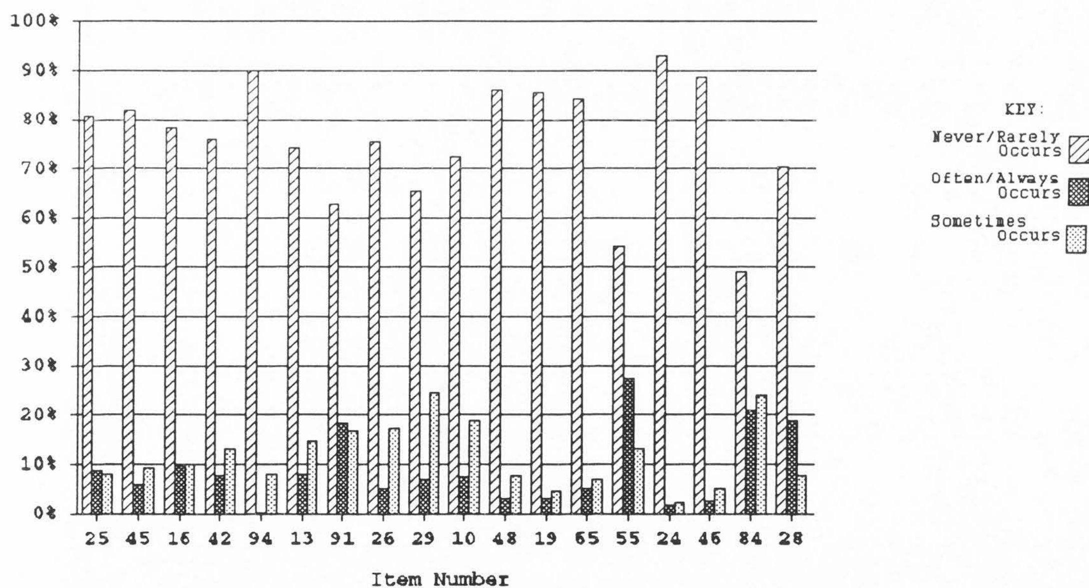
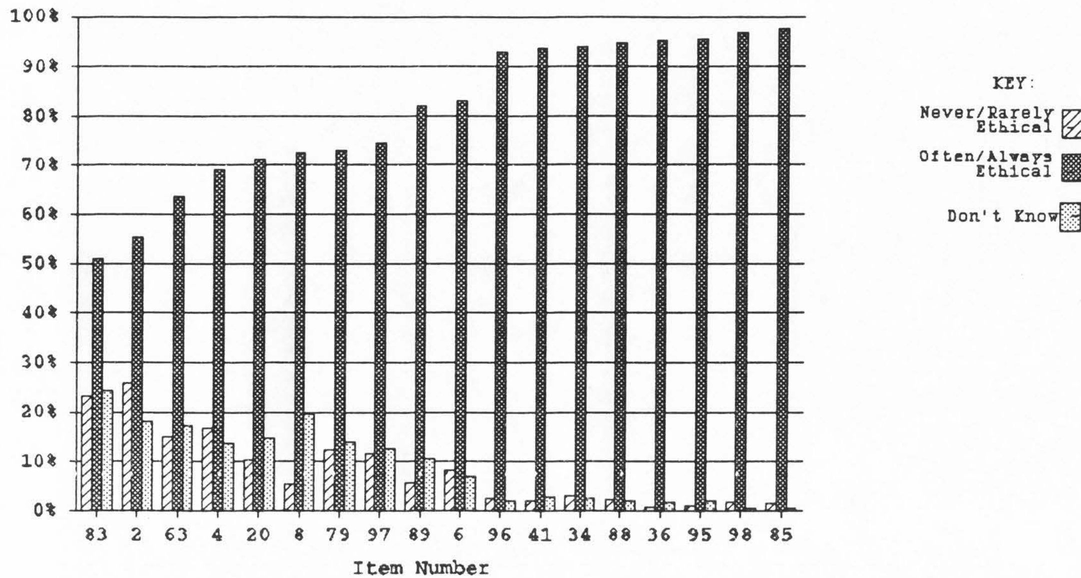


Figure 3. Percentage of responses to behavior items in each category from the professional practice scale.

(figure continues)

How ethical is this behavior?



How often does this behavior occur in your practice?

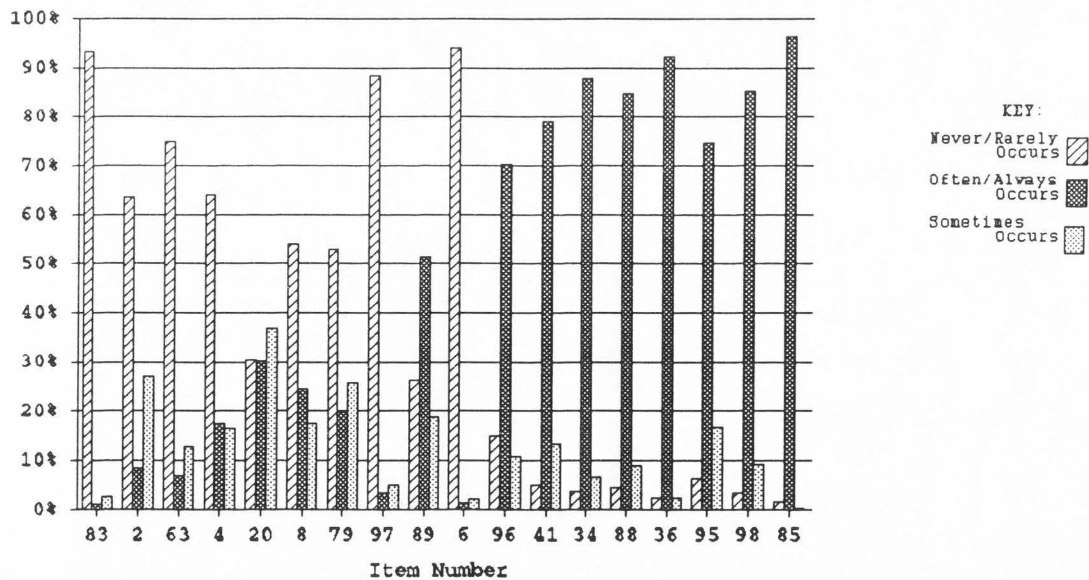


Figure 3. Percentage of responses to behavior items in each category from the professional practice scale.

practiced behavior is defined as those behaviors where at least 85% of the respondents report that the behavior "often" or "always" occurs in their practice.

Thirteen of the 99 behaviors were universally accepted as ethical (i.e., over 85% of respondents answered either "always ethical" or "often ethical"). Three of these behaviors involved breaking confidentiality if the client is homicidal, suicidal, or to report child abuse. Two of the behaviors were from the dual relationship scale: having clients address you by your first name and offering or accepting a handshake from a client. Of the remaining eight behaviors from the professional practice scale, six involved accepted professional behaviors with clients: "clearly defining criteria to determine whether the client is benefiting from treatment"; "using individualized treatment plans"; "revising treatment plans regularly"; "using written informed consent procedures"; "addressing the client by his or her first name"; and "explaining the biofeedback process." The remaining two behaviors involved professional practice not directly related to interactions with clients: "consultation with colleagues on a regular basis" and "keeping updated on ethical principles and state laws that effect your biofeedback practice."

Of these 13 behaviors, 9 are reportedly practiced by more than 85% of the respondents at least sometimes: "having clients address you by your first name"; "offering or accepting a handshake from a client"; "revising treatment plans regularly"; "addressing the client by his or her first name"; "clearly defining criteria to determine whether the client is benefiting from treatment"; "using individualized treatment plans"; "explaining the biofeedback process"; "consultation with colleagues on a regular basis"; and "keeping updated on ethical principles and state laws that effect your biofeedback practice." Eighty-one percent of the respondents use written informed consent procedures at least sometimes.

Behaviors Universally Accepted as Unethical

Behaviors that are universally accepted as unethical are defined as those behaviors where at least 85% of the respondents report that the behavior is "rarely" or "never" ethical. Rarely

practiced behavior is defined as those behaviors where at least 85% of the respondents report that the behavior "rarely" or "never" occurs in their practice.

Fifteen of the 99 behaviors were universally accepted as unethical (i.e., over 85% of respondents answered either "never ethical" or "rarely ethical"). Two of these behaviors involved breaking confidentiality: "unintentionally disclosing confidential information" and "discussing a client (by name) with friends."

Six of these behaviors involved dual relationships, five with clients: "engaging in sexual contact with a client"; "engaging in erotic activity with a client"; "telling a client 'I'm sexually attracted to you.'"; "dressing seductively for sessions with clients"; "borrowing money from a client"; and one with clinical supervisees: "engaging in sex with a clinical supervisee."

The remaining eight behaviors were from the professional practice scale. Five involved inappropriate professional behaviors with clients: "doing therapy while under the influence of alcohol"; "disrobing in the presence of a client"; "providing services outside one's areas of competence"; "continuing services to a client when the client is no longer receiving any benefit"; and "allowing a client to disrobe in your presence." One behavior involved inappropriate professional behavior with clinical supervisees: "signing for hours a clinical supervisee has not earned." The remaining behavior involved professional practice not directly related to behaviors with clients or supervisees: "getting paid to refer clients to someone."

Behaviors that rarely occur in practice (i.e., over 85% of respondents answered either "Never occurs" or "Rarely occurs") include all the above unaccepted behaviors and 35 other behaviors. Two of these behaviors come from the confidentiality scale: "limiting treatment notes to name, date, and fee"; and "seeing a minor client without parental consent."

Seventeen of these rarely practiced behaviors come from the professional practice scale. Eight of these behaviors involved the professional practices directly related to client services: "deceiving clients for their own good"; "crying in the presence of a client"; "accepting only male or female clients"; "treating homosexuality per se as pathological"; "refusal to treat clients with

AIDS"; "accepting a client's decision to commit suicide"; "avoiding certain clients for fear of being sued"; and "terminating services to a client because you are sexually attracted to them." The other nine behaviors from the professional practice scale involved professional practice not directly related to client services: "filing an ethics complaint against a colleague"; "performing forensic work for a contingency fee"; "working when too distressed to be effective"; "making custody evaluations without seeing the child"; "refusing to disclose a diagnosis to a client"; "using a law suit to collect fees from clients"; "doing custody evaluations without seeing both parents"; "directly soliciting a person to be a client"; "helping a client file a complaint about a colleague";

Sixteen of these behaviors were from the dual relationship scale: "becoming sexually involved with a former client"; "accepting services from client in lieu of fee"; "accepting a client's gift worth at least $50"; "accepting goods (rather than money) as payment"; "inviting clients to a party or social event"; "asking favors (e.g., a ride home) from clients"; "providing therapy to your student supervisee"; "lending money to a client"; "providing therapy to one of your employees"; "kissing a client"; "giving a gift worth at least $50 to a client"; "accepting a client's invitation to a party"; "going into business with a client"; "borrowing money from a client"; "going into business with a former client"; and "paying undue attention to client's dress and appearance."

Controversial Behaviors

Pope et al. (1987) defined controversial items as those items where more than 20% of their homogenous sample responded "don't know/not sure." Due to the heterogeneity of the current sample this definition does not apply. The controversial items from Pope et al. had an overall agreement rating of less than 60%; therefore controversial items in the current survey are those items where fewer than 60% of the respondents agree on the ratings. Figure 4 presents the mean response by education level and major discipline for reported ethical beliefs for controversial

items from the dual relationship scale. Figure 5 presents the mean response by education level and major discipline of reported ethical beliefs for controversial items from the professional practice scale. There were no controversial items from the confidentiality scale for reported ethical beliefs. Figure 6 presents the mean response by education level and major discipline of reported occurrence in practice for controversial items from all three scales. As can be seen from these figures there is a trend for respondents with less education to be more polarized in their response style on these controversial items.

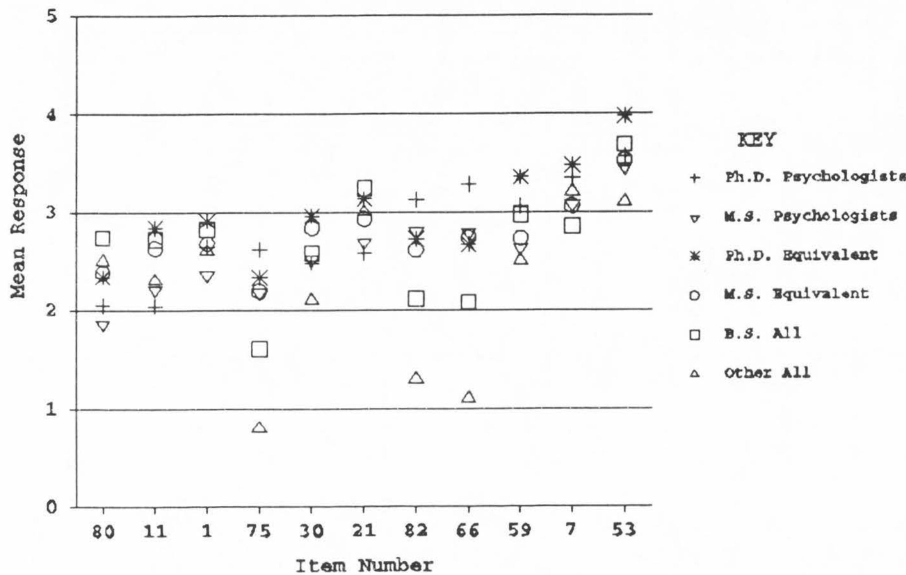


Figure 4. Mean response by education level of reported ethical beliefs for controversial items from the dual relationship scale.

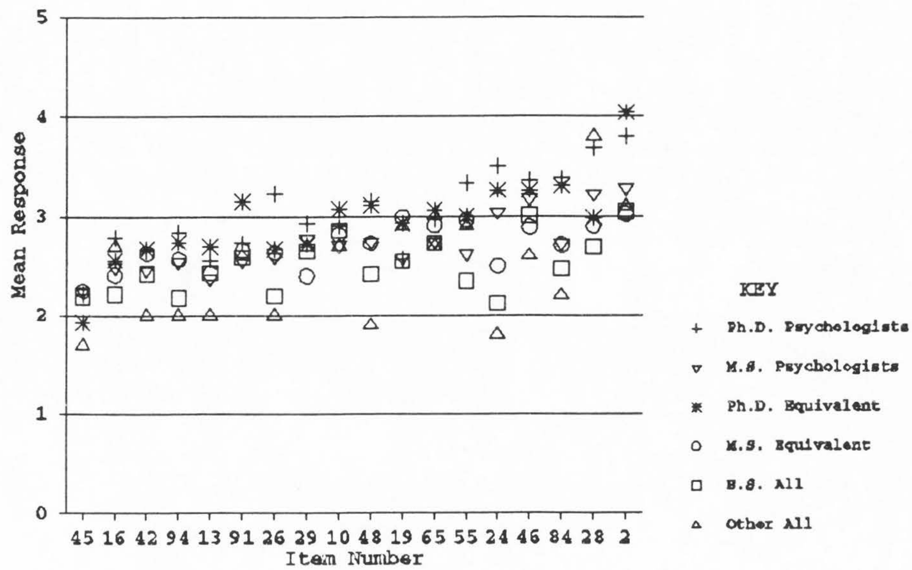


Figure 5. Mean response by education level of reported ethical beliefs for controversial items from the professional practice scale.

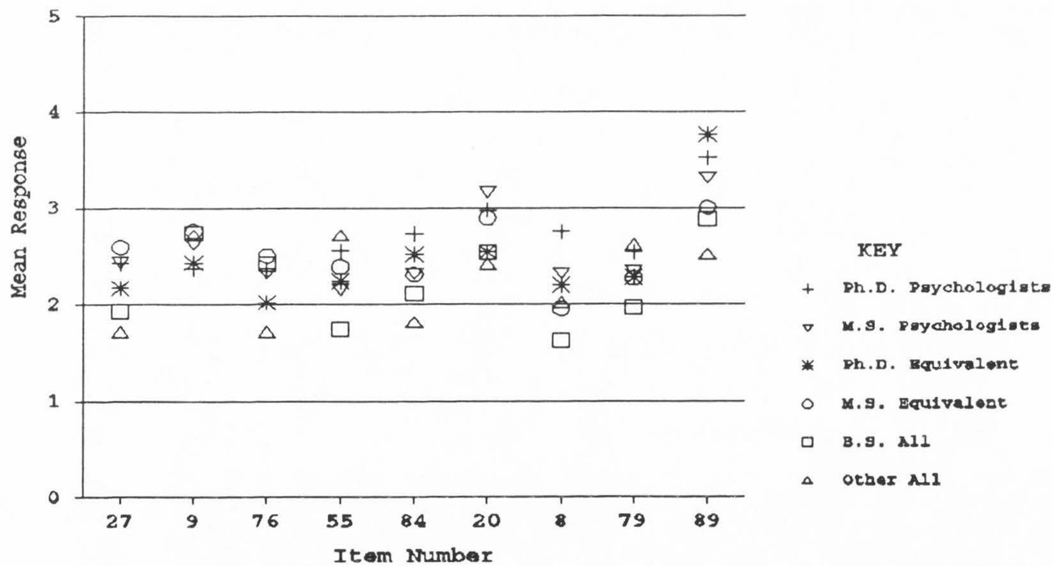


Figure 6. Mean response by education level of reported occurrence in practice for controversial items from all scales.

There were 29 controversial behaviors; 10 of these behaviors were from the dual relationship scale. Two of the items involved controversial relationships in fee arrangements with clients: "accepting service from a client in lieu of a fee" and "accepting goods (rather than money) as payment." Five of these behaviors involved social relationships with clients outside the professional relationship: "going into business with a former client"; "becoming social friends with a client"; "inviting clients to an office open house"; "going to a client's special event (e.g., wedding)"; and "sending holiday greeting cards to your clients." Three items involved personal issues for the professional that could place them in a dual relationship without the client's knowledge: "engaging in a sexual fantasy about a client"; "being sexually attracted to a client"; and "telling a client you are angry at him or her."

The remaining 19 behaviors were from the professional practice scale. Six items involved client fees: "raising the fee during the course of therapy"; "allowing clients to run up a large unpaid bill"; "terminating therapy if the client cannot pay"; "performing forensic work for a contingency fee"; "using a law suit to collect fees from clients"; and "charging a client no fee for therapy." Two of these behaviors involved the professional's emotional reactions to a client: "telling clients of your disappointment in them" and "crying in the presence of a client." Seven of these behaviors involved professional behaviors directly relating to clients: "refusing to let clients read their chart notes"; "having clients take tests (e.g., MMPI) at home"; "using the same biofeedback instructions for all clients"; "obtaining only verbal permission to treat a client"; "telling clients what they should do"; "not allowing clients access to raw test data"; and "helping a client file a compliant about a colleague." Four of these behaviors involved professional practice not directly related to clients: "giving gifts to those who refer clients to you"; "avoiding certain clients for the fear of being sued"; "giving personal advice on radio, T.V., etc."; and "accepting only male or female clients."

Reportedly, all of these controversial items were practiced rarely or never by more than 60% of the respondents. There are nine behaviors where there was a greater than 60% agreement

among the respondents that these behaviors are often or always ethical, but where less than 60% of the respondents agree on how often the behavior occurs in practice. One behavior, "breaking confidentiality if the client is suicidal" is from the confidentiality scale. Two behaviors are from the dual relationship scale: "hugging a client" and "accepting a gift worth less than $5 from a client." Six of the behaviors were from the professional practice scale: "obtaining only verbal permission to treat a client"; "telling clients what they should do"; "using self-disclosure as a therapy technique"; "using a computerized testing service"; "charging for missed appointments"; and "establishing individual contracts for clients for services."

Expected Discrepancies

Based on the results of the surveys conducted by Pope et al. (1987) and by Conte et al. (1989) is was expected that items such as breaking confidentiality to report expected harm to client or others and filing an ethics compliant against a colleague would be considered highly ethical but rarely practiced. Figure 7 presents the response rates to the current survey for those items where a high response rate in the often and always ethical categories and in the never and rarely occurs categories were expected.

Ethical Differences Across Health-Care Professions

The second question to be answered is: How did the ethical beliefs and behaviors of psychologists who are members of the AAPB compare to other professionals and paraprofessionals who are also members of the AAPB? These differences or similarities were examined based on educational level, licensure status and biofeedback certification status within each subgroup. To answer this question a nested Analysis of Variance (ANOVA) was used to determine the statistical differences between the responses of each group. Factor one for this ANOVA is discipline by educational level (i.e., Ph.D. psychologists, other Ph.D. equivalent professionals, M.S. psychologists, other M.S. equivalent professionals, all B.S. level respondents, and less than B.S.

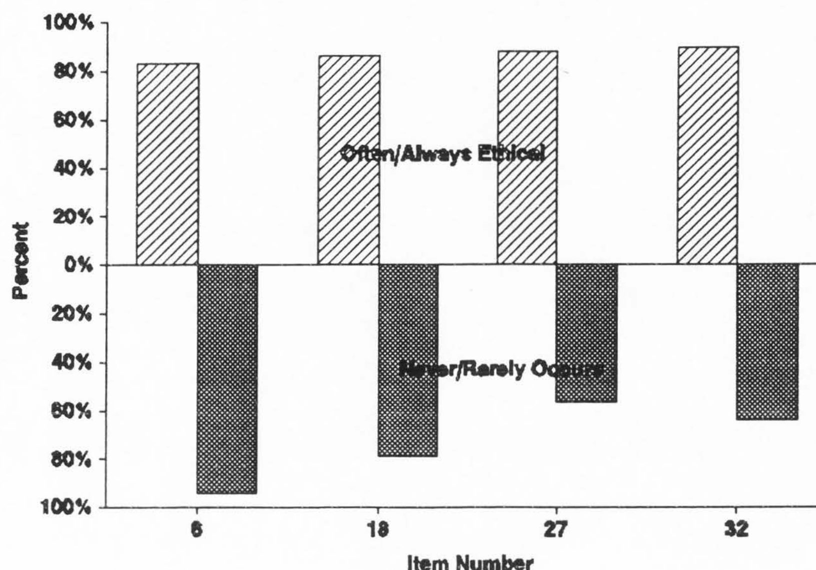


Figure 7. Response rate from current survey on behavior items where a high response rate in the often and always ethical categories and in the never and rarely occurs categories were expected.

level respondents). Each group was further divided or "nested" into subgroups based on licensure status and certification status.

There are six outcome or dependent variables. These variables were obtained by summing the respondents' ratings for behaviors in each general area of ethical behavior (i.e., dual relationships, professional practice, and confidentiality) for each question asked about the behavior (i.e., How often does this behavior occur in your practice? and How ethical is this behavior?). Due to the potential number of comparisons that can be made, a very strict significance level ($p < .001$) was used. Figure 8 presents the ANOVA table as described.

The results of the ANOVA were that there are no statistically significant differences between the reported ethical beliefs and practices of the psychologists sampled and any of the other health-care professions sampled. Tables 8, 9 and 10 present the levels of results of the univariate F-tests from the ANOVA.

		Psychologists				Other Professionals						Paraprofessionals				
How ethical is this behvior?	Dual Relationships	Ph.D		MS MA		Ph.D. M.D.		MS MA		BS BA		BS BA		other		Education
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Licensed ?
		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Certified ?
	Professional Practice	Ph.D		MS MA		Ph.D. M.D.		MS MA		BS BA		BS BA		other		Education
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Licensed ?
		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Certified ?
	Confidentiality	Ph.D		MS MA		Ph.D. M.D.		MS MA		BS BA		BS BA		other		Education
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Licensed ?
		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Certified ?
How often does this behavior occur in your practice?	Dual Relationships	Ph.D		MS MA		Ph.D. M.D.		MS MA		BS BA		BS BA		other		Education
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Licensed ?
		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Certified ?
	Professional Practice	Ph.D		MS MA		Ph.D. M.D.		MS MA		BS BA		BS BA		other		Education
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Licensed ?
		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Certified ?
	Confidentiality	Ph.D		MS MA		Ph.D. M.D.		MS MA		BS BA		BS BA		other		Education
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Licensed ?
		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Certified ?

Figure 8. ANOVA table used to analyze the results of this survey.

Table 8

Results of Univariate F-Tests for the Effect: Certification Status within Licensure Status within Educational Level and Discipline (DF = 12, 471)

How ethical is this behavior?				
Variable	SS	MS	F	Sign. of F
Dual Relationships	3557.132	296.427	1.024	.425
Professional Practice	3951.818	329.318	0.969	.477
Confidentiality	292.444	24.370	1.323	.201

How often does this behavior occur in your practice?				
Variable	SS	MS	F	Sign. of F
Dual Relationships	534.766	44.564	0.399	.964
Professional Practice	2525.091	210.424	0.754	.698
Confidentiality	222.766	18.564	0.798	.653

Table 9

Results of Univariate F-Tests for the Effect: Licensure Status within Educational Level and Discipline (DF = 6,12)

How ethical is this behavior?

Variable	SS	MS	F	Sign. of F
Dual Relationships	1268.475	211.412	0.713	.646
Professional Practice	2852.924	475.487	1.444	.276
Confidentiality	257.825	24.370	1.763	.190

How often does this behavior occur in your practice?

Variable	SS	MS	F	Sign. of F
Dual Relationships	525.589	87.598	1.966	.150
Professional Practice	1107.223	184.537	0.877	.540
Confidentiality	209.775	34.962	1.883	.165

Table 10

Results of Univariate F-Tests for the Effect: Educational Level and Discipline (DF = 5,6)

How ethical is this behavior?

Variable	SS	MS	F	Sign. of F
Dual Relationships	2474.030	494.806	2.340	.165
Professional Practice	7174.202	1434.840	3.018	.106
Confidentiality	412.992	82.598	1.922	.225

How often does this behavior occur in your practice?

Variable	SS	MS	F	Sign. of F
Dual Relationships	636.386	127.277	1.453	.328
Professional Practice	2429.531	485.906	2.633	.135
Confidentiality	311.988	62.398	1.785	.250

Due to the trend for less educated respondents to be more polarized in their response style on controversial items, post hoc ANOVAs were conducted, comparing the respondents' age and years in practice to the six outcome measures. As can be seen from Tables 11 and 12 there are no statistically significant differences in the respondents' reports based on age or years in practice.

Pope et al. (1987) reported significant gender differences in the ethical beliefs and practices of health-care professionals. To assess these differences in the current survey chi-square analyses were preformed. Due to the large number of analyses, a significance level of $p < .001$ was used. Table 13 presents the items significantly related to gender on the "how ethical is this behavior scale." Table 14 presents the items significantly related to gender on the "how often does this behavior occur in your practice scale."

Written Comments from Respondents

Written comments were provided by 182 or 34% of the respondents. Of those responding with written comments, 91 (50%) made comments that qualified their responses. Thirty (16%) did not like the wording of the sexual attraction or fantasy questions, while an additional 9 (5%) did not like any of the questions regarding the professionals' feelings. Twenty-three (13%) thought that question 99 concerning talking about clients with other family members was too vague. Eighteen (10%) made overall positive comments about the survey, while 8 (4%) made overall negative comments. Fifteen (8%) did not like the scale used in the survey. Five (3%) suggested additional behavior items that should be considered in future research. The percentages do not add to 100% because some respondents made more than one type of comment.

Table 11

Results of Univariate F-Tests for the Effect: Respondents' Age (DF = 6,511)

How ethical is this behavior?

Variable	SS	MS	F	Sign. of F
Dual Relationships	2008.125	334.687	1.208	.301
Professional Practice	4138.185	689.697	1.827	.092
Confidentiality	66.373	11.062	0.553	.768

How often does this behavior occur in your practice?

Variable	SS	MS	F	Sign. of F
Dual Relationships	367.953	61.326	0.446	.848
Professional Practice	2478.414	413.069	1.102	.360
Confidentiality	37.806	6.301	0.243	.962

Table 12

Results of Univariate F-Tests for the Effect: Respondents' Years in Practice (DF = 4,504)

How ethical is this behavior?				
Variable	SS	MS	F	Sign. of F
Dual Relationships	2583.917	645.979	2.222	.066
Professional Practice	4112.536	1028.134	2.656	.032
Confidentiality	79.801	19.950	1.003	.405

How often does this behavior occur in your practice?				
Variable	SS	MS	F	Sign. of F
Dual Relationships	815.377	203.844	1.586	.177
Professional Practice	2339.407	584.852	1.684	.152
Confidentiality	100.070	25.018	0.994	.410

Table 13

Items Significantly Related to Gender on the "How Ethical is this Behavior" Scale (df = 5, $p <$ .001) *

Item	Chi-squared
2. Charging a client no fee for therapy.	31.579
13. Having clients take tests at home.	29.508
15. Telling client: "I'm sexually attracted to you."	34.440
19. Preforming forensic work for a contingency fee.	58.596
24. Accepting only male or female clients.	20.330
31. Refusal to treat clients with AIDS.	34.745
46. Using a law suit to collect fees from clients.	25.681
48. Avoiding clients for fear of being sued.	26.396
49. Doing custody evaluations without seeing both parents.	24.259
55. Obtaining only verbal permission to treat client.	21.021
63. Utilizing involuntary hospitalization.	26.366
66. Being sexually attracted to a client.	49.641
75. Engaging in sexual fantasy about a client.	55.015
82. Being sexually attracted to a client.	47.756
83. Helping a client file a compliant about a colleague.	35.112
84. Telling clients what they should do.	41.693
90. Deceiving clients for their own good.	39.987

* Female respondents believed all items to be less ethical than male respondents except for item 19 where female respondents responded "did not know" more often.

Table 14

Items Significantly Related to Gender on the "How Often does this Behavior Occur in your Practice" Scale (df = 5, $p < .001$) *

Item	Chi-square
8. Using a computerized testing service.	26.697
9. Hugging a client.	40.332
13. Having clients take tests at home.	26.524
25. Not allowing clients access to testing report.	28.767
28. Not allowing clients access to raw test data.	31.233
52. Having a client address you by your first name.	84.394
63. Utilizing involuntary hospitalization.	38.450
66. Being sexually attracted to a client.	80.451
75. Engaging in sexual fantasy about a client.	81.166
82. Being sexually attracted to a client.	82.315
83. Helping a client file a compliant about a colleague.	29.216
84. Telling clients what they should do.	29.984

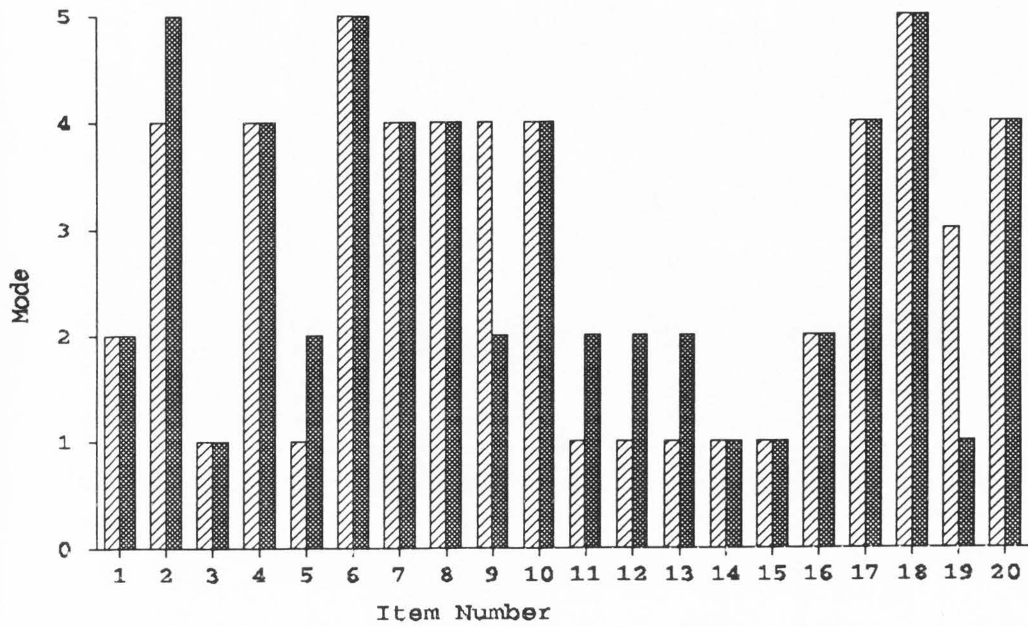
* Female respondents report they practice these behaviors less than male respondents, with the exception of items 9 and 52.

Comparison to Pope

Of the 99 items on the current survey, 80 where asked on the survey by Pope et al. (1987). Figure 9 presents the mode responses from the current survey compared to the mode responses for Pope et al. for the question: How ethical is this behavior? Figure 10 presents the mode responses to the question: How often does this behavior occur in your practice? The mode response is used in Figures 9 and 10 because the response pattern between the two surveys is similar and the mode most clearly shows the differences in the trends of the two surveys.

As can be seen in Figure 9 the mode response from the current survey and from Pope et al. (1987) for the question, "How ethical is this behavior?" is the same for 57 of the 80 matched items. There is a one point spread for 14 of the matched items with the respondents from Pope et al. listing the items as one point more ethical on 12 of the items. For three items with a one point spread the current respondents' mode response was "3 - don't know/not sure" while the respondents from Pope et al. responded "2 - rarely ethical" for two of the items and "4 - often ethical" for the remaining item. There is a two point spread between samples on eight of the items with the current respondent responding "3 - don't know/not sure" for five items and the respondents from Pope et al. responding "3 - don't know/not sure" on one item. There is a three point spread in the mode responses on one item.

As can be seen in Figure 10 the mode response from the current survey and from Pope et al. (1987) for the question, "How often does this behavior occur in your practice?" is the same for 67 of the 80 matched items. There is a one point spread for 10 of the matched items with the respondents from Pope et al. listing the items as occurring more often by one point on all 10 of the items. There is a two point spread between samples on three of the items with the respondents from Pope et al. listing the behavior as occurring more often for all three items.



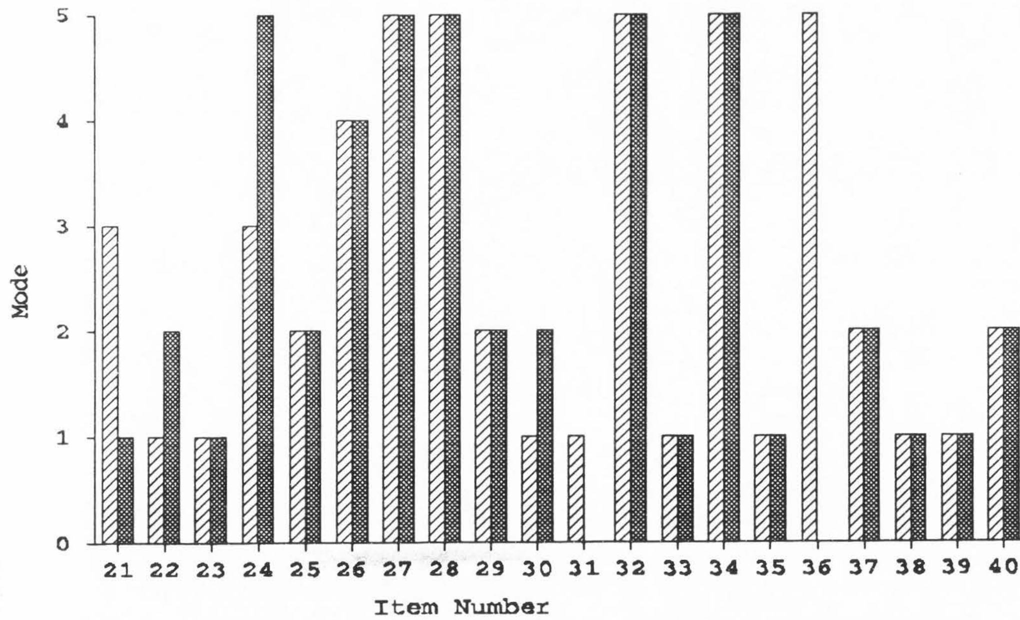
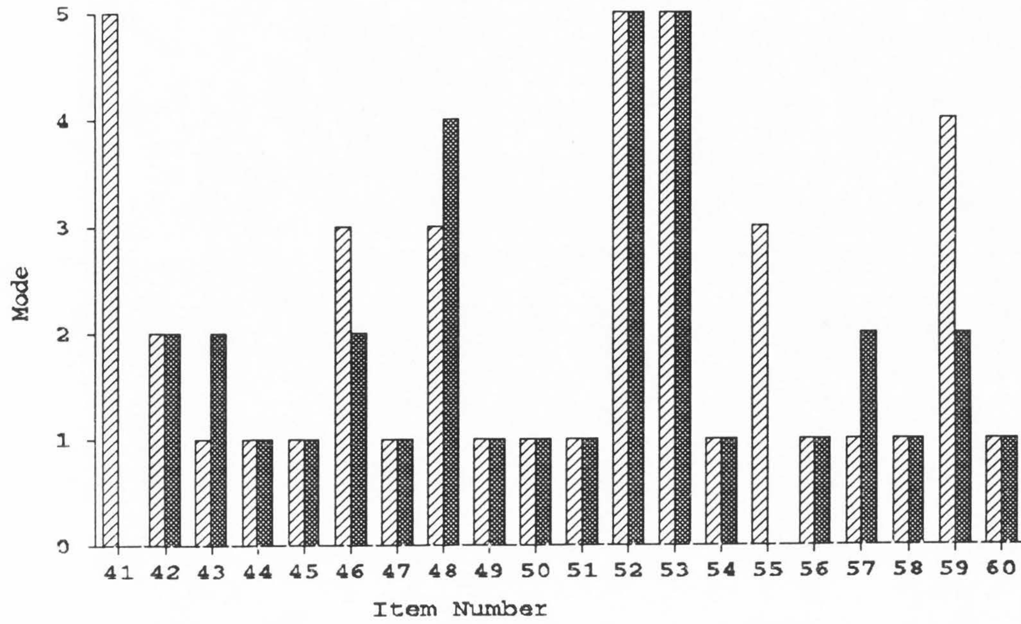
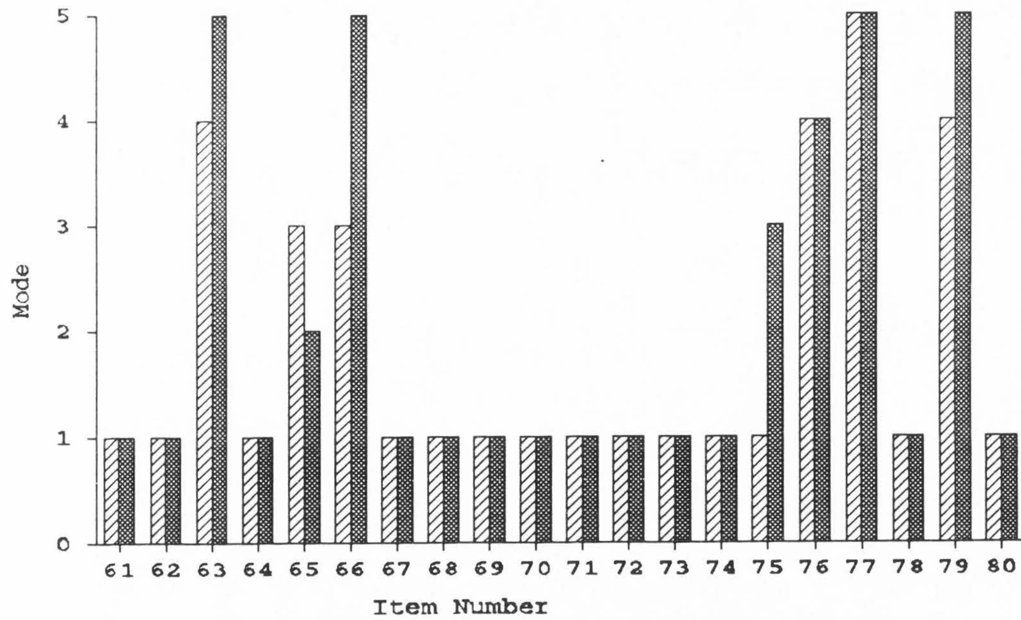


Figure 9. Comparison of mode responses from current survey to similar items from Pope et al. (1987) for the question: How ethical is this behavior?

(figure continues)





- Percival (1991) - Pope et al. (1987)

Figure 9. Comparison of mode responses from current survey to similar items from Pope et al. (1987) for the question: How ethical is this behavior?

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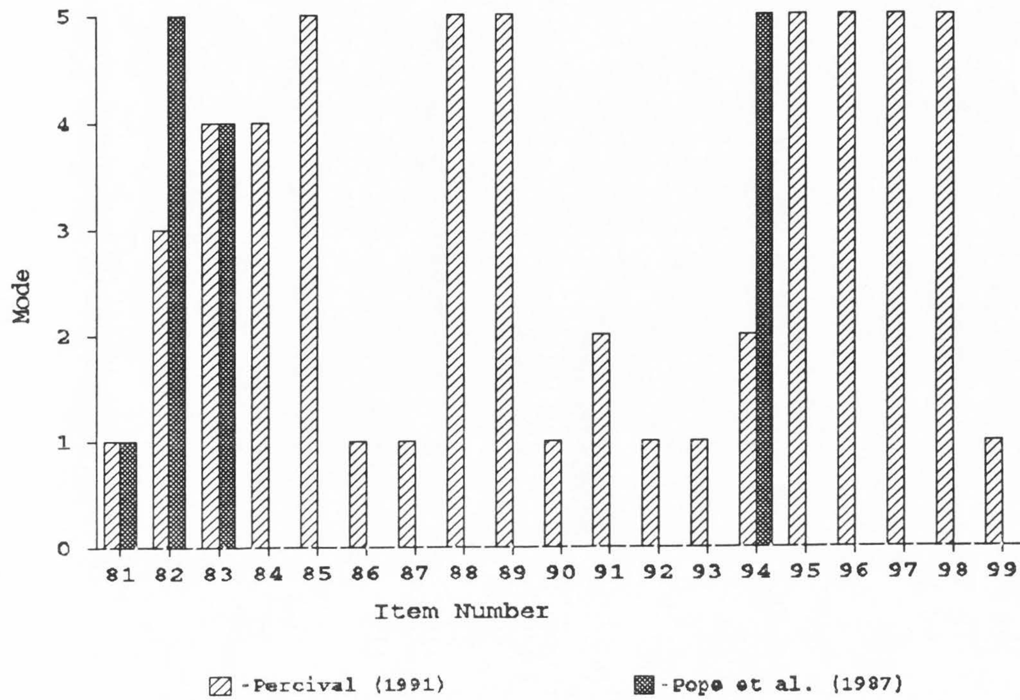

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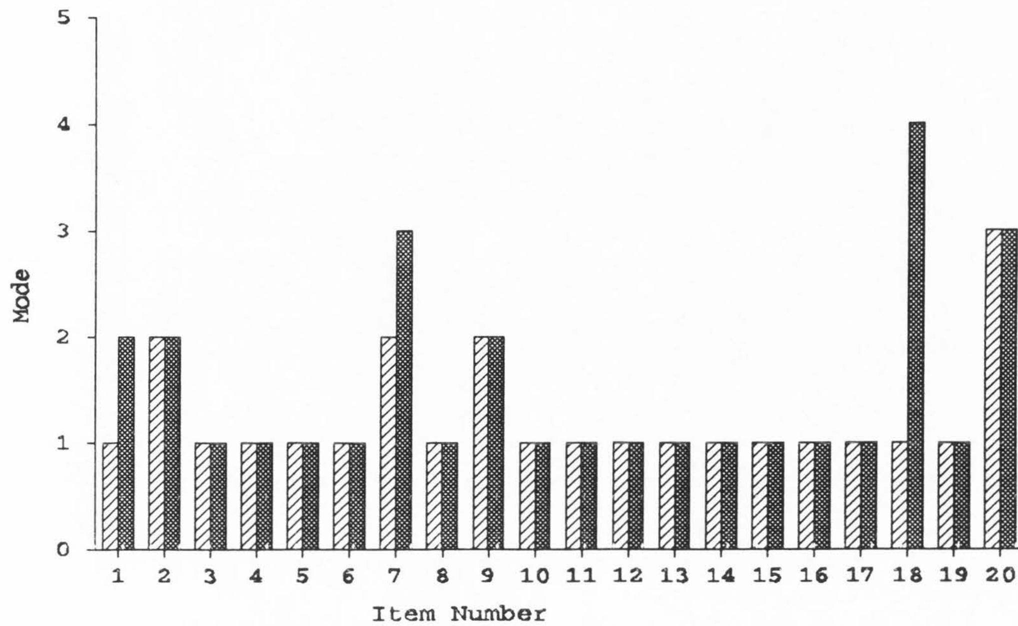


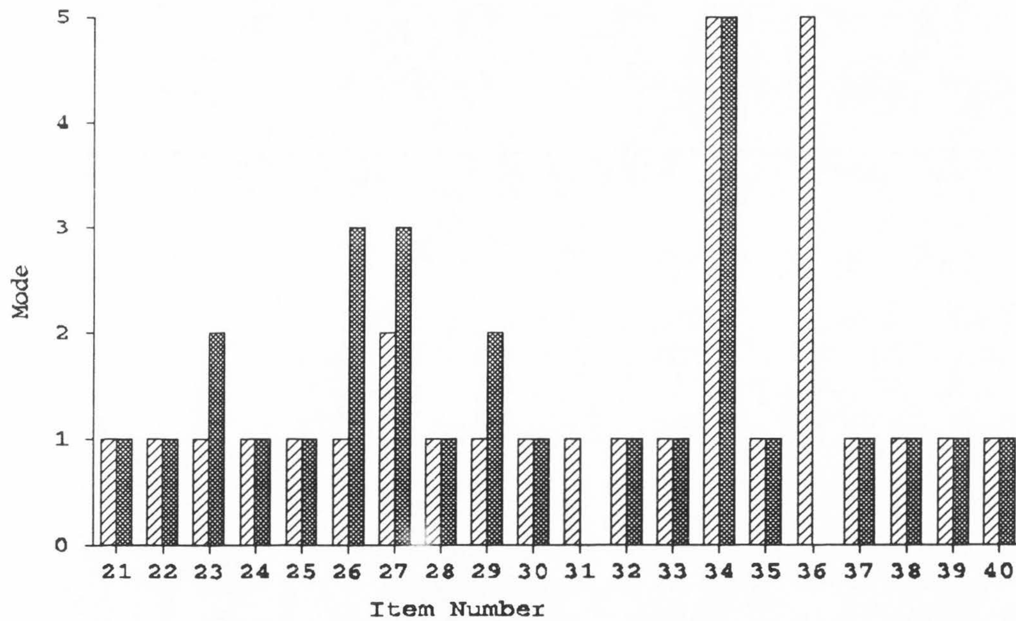
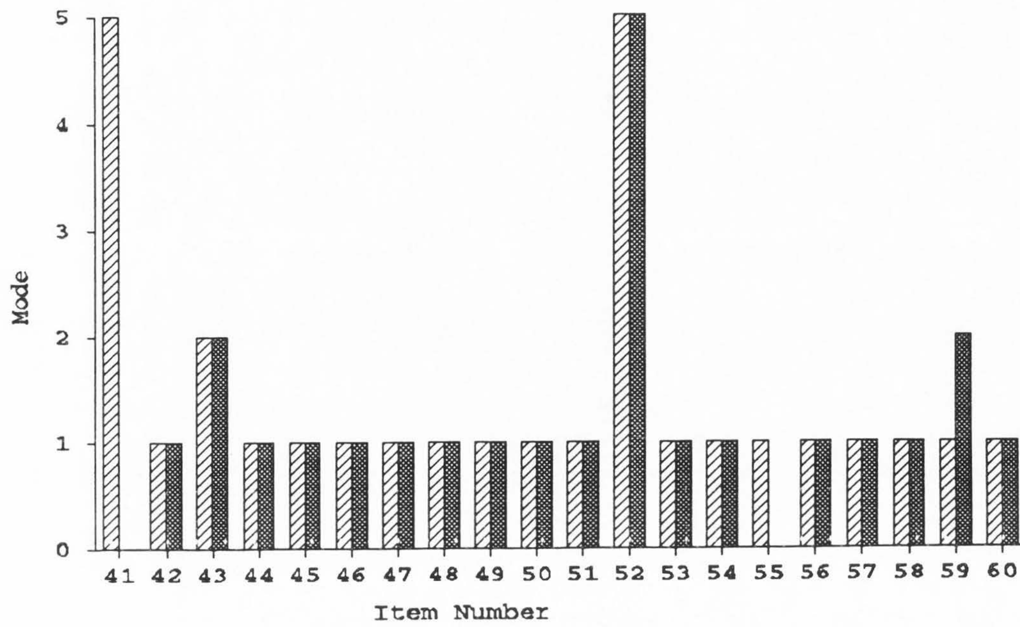


Figure 10. Comparison of mode response from current survey to similar items from Pope et al. (1987) for the question: How often does this behavior occur in your practice? (figure continues)



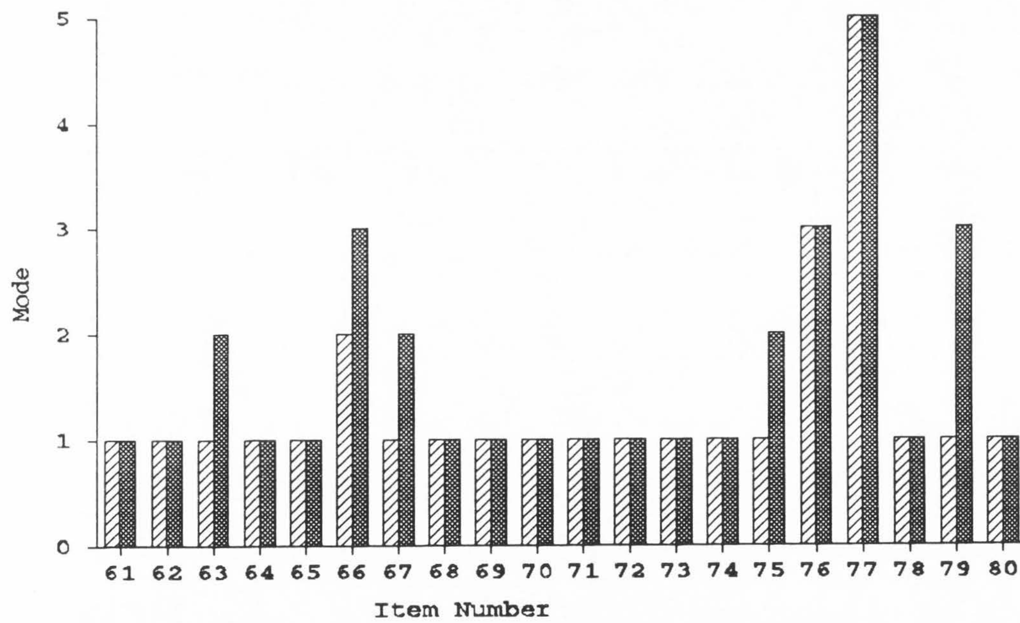


Figure 10. Comparison of mode response from current survey to similar items from Pope et al. (1987) for the question: How often does this behavior occur in your practice? (figure continues)

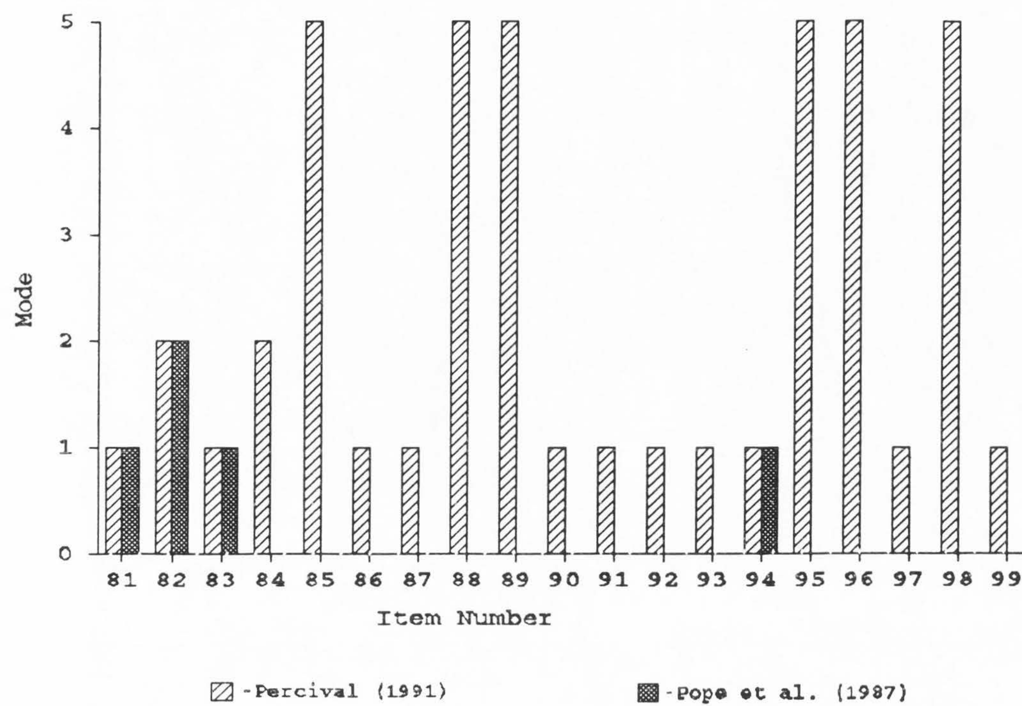


Figure 10. Comparison of mode response from current survey to similar items from Pope et al. (1987) for the question: How often does this behavior occur in your practice?

CHAPTER VI

DISCUSSION

In this chapter, general findings of the survey are discussed. The limitations of the survey including threats to internal and external validity and problematic questions will be presented. The chapter will conclude with recommendations for the use of the results of this survey and with recommendations for future research.

Reported Ethical Beliefs and Practices Across Discipline

The statistical differences reported and shown in Tables 8, 9, 10, 11, and 12 indicate that the reported ethical beliefs and behaviors of health-care professionals responding to this survey are basically the same regardless of discipline, licensure and certification statuses, and age or years of practice in the areas of confidentiality, dual relationships and professional practice. The statistical differences reported and shown in Tables 13 and 14 indicate that there are gender differences in the reported ethical beliefs and practices of health-care professionals. These findings are consistent with the two previous questionnaires that compared psychologists to other mental health-care professionals (Borys and Pope, 1989; Conte et al., 1989), yet are contrary to previous reports in the literature that detail concerns about multidisciplinary practice (Pope, 1990).

Conte et al. (1989) and Borys and Pope (1989) compared the ethical beliefs of psychologists, psychiatrists, and social workers. Conte et al. conducted a survey on general ethical attitudes and reported:

> very few significant differences in attitudes between psychiatrists, psychologists, and social workers. What differences did exist were over relatively minor matters such as eating during a patient's session. (p.36)

Borys and Pope's survey compared ethical beliefs and behaviors on dual relationship issues. They reported:

> There was no significant difference among the professions in terms of (a) sexual intimacies with clients before or after termination of therapy, (b) nonsexual dual professional roles, (c) social involvements, or (d) financial involvements with patients. (p. 290)

In his 1990 article "Ethical and Malpractice Issues in Hospital Practice," Pope described several case studies where psychologists had difficulty merging their ethical beliefs and standards with "common" practice in hospital settings. Professional literature on ethics is full of articles detailing and describing the unique ethical problems for one profession or one type of client being served.

Of the respondents who made comments, 91 (50%) qualified their answers by indicating that due to their discipline or work setting, their ethical beliefs and standards are necessarily different:

> As an occupational therapist I believe traditional O.T. [occupational therapy] ethics are sometimes different than ethics to be used with psychologists or with biofeedback tx [treatment](especially if it addresses mental health issues). i.e., In O.T. I would tx (treat) a friends fractured arm and might make recommendation for self-regulation techniques. However, I generally refer to others for bfbk (biofeedback) with pain issues; This questionnaire can only be valid within the context of a respondent's profession, for example: Allied health-care professionals discuss patients all the time. Psychologists rarely do, or so I am told; BFB [biofeedback] therapists get involved in situations that other psychologists never would (i.e. unbuttoning blouse to place electrodes); This was written for psychologists - for example question 68 - disrobing - occurs frequently in P.T. [physical therapy], O.T., Nursing; Many of these responses are explained by the fact I work in a referral setting where we often tell people what to do, restrict practice to one sex or another and try to maintain consistency across pts [patients]. Obviously, many of my responses would be quite different were I working in a mental health clinic. Please be sure your report of these results is tempered by the limitations of this forced choice format; Non-sexual quick "pecks" on the cheek with some of the society ladies in this town are a social greeting norm; I am the only biofeedback therapist in my area. Social contacts and professional contacts with clients are fairly frequent. My husband is a physician and my business can sometimes be somewhat of a family affair. Confidentiality is always respected but we are somewhat unique because of our location; Living in a small town social contact is inevitable - I leave it up to the patients to decide if they want it known that they have seen me professionally.

Even though the health-care professionals who responded to this survey believe there are necessary ethical differences between practices, they report similar ethical beliefs and practices regardless of discipline and licensure or certification status. Are ethical differences across professions inherent or is this belief a myth? It seems logical that there are inherent ethical

differences across disciplines (i.e., it is probably very ethical for a nurse to give a bed ridden patient a sponge bath but it is not ethical for the same patient's psychotherapist to perform the same task. Yet, these inherent differences were not found in this survey, even on items such as "allowing a client to disrobe in your presence."

It seems as though there are fewer ethical differences between professions than is commonly believed, yet ethical controversies between health-care professionals continue to arise in settings where professionals from various disciplines work together. In Pope's 1990 article the case studies presented pitted psychologists' ethical beliefs against the practices of hospital administrations and insurance companies, not against the other health-care professions. Could it be that some or most of the ethical beliefs of health-care professionals are basically the same and that the ethical controversies between health-care professions lie in the administrative styles of hospitals verses clinics verses private practice? This is a question that needs to be answered by future studies.

Gender Differences

The are several clinically and statistically significant trends between female and male health-care professionals in their reported ethical beliefs and behaviors. Female respondents believe that it is less ethical to avoid or refuse to treat clients that may require special considerations. For example, refusing to treat clients with AIDS, treating only male or female clients, or refusing to treat client due to fear of being sued, were all rated as less ethical by female respondents; yet the frequency with which the behavior reportedly occurred, between male and female respondents in these areas was the same. Consistent with Pope et al. (1987) male respondents were more likely to be sexually attracted to a client, engage in sexual fantasies about clients, and engage in sexual contacts with clients. Males are also more likely than females to believe that these behaviors are ethical. Also consistent with Pope et al., female respondents report the same beliefs as males in regards to hugging clients and having clients use the

professional's first name, yet they report that they engage in these behaviors significantly more than males.

There are many factors that could account for the gender differences found in this survey. Among these factors could be traditional gender roles, choice of discipline and work setting, geographical area, and the type of clients being seen. Perhaps, more important than discovering why there are gender differences among health-care professionals is discovering what the impact is of these differences, in terms of quality of treatment provided to clients, client welfare, and professional burn-out. These are all questions that need to be addressed in future research.

Ethical Attitudes and Education

There is a clinically important but statistically insignificant trend for respondents with less education to be more polarized in their response style on controversial items. For example, when the controversial items are plotted by the respondents' education level, the more conservative results come from those respondents with less than a bachelors degree, especially on items related to the professional's feelings about the client (i.e., "being sexually attracted to a client"; "expressing your disappointment with a client"; "crying in the presence of a client") and professional practice (i.e., "having clients take tests at home"; "accepting only male or female clients") (see Figures 8, 9, and 10).

This trend may be the result of a lack of ethical education and experience at the lower levels of education. In a review of 250 psychology and counseling texts, Baldick (1980) found that only 2.8% discussed professional ethics. Gaul (1989) reviewed all fundamental nursing texts published between 1965 and 1985 and found that 45% of the texts made no reference to ethics and only two of the texts devoted a whole chapter to the discussion of ethics. Two biofeedback practitioners who responded to this survey support the need for more ethical education with their comments:

> Critical issues for biofeedback are ones of extent of touch during treatment. No courses are given to my knowledge in how to do such activities, leading to blind alleys or worse

for therapists. More in these areas needs to be clarified; and Biofeedback therapists need more education to be aware of transference and counter-transference issues.

Trainees are students who are gaining practical experience and education by working in actual helping positions. Paraprofessionals are usually individuals with less education who are hired as technical assistants to health-care professionals. Trainees and paraprofessionals are increasingly being used in the health-care professions to offset the exploding costs of providing services. With the use of trainees and paraprofessionals the ethical responsibility of the supervising professional also increases. It is the supervising professional's responsibility to monitor their own ethical behaviors as well as the behavior of those they supervise (Roswell, 1989; Sullivan & Brown, 1989).

Supervision can often be difficult and Roswell (1989) lists failure to properly supervise trainees as a major cause of law suits against mental health-care professionals. Borys and Pope (1989) indicate that there is a need for clarifying the standards of dual relationships between students and educators. This need for clarification is supported by results of the current survey. Three questions on the current survey dealt directly with health-care professionals' behaviors toward their supervisees. Two of the items, engaging in sex with a clinical supervisee and signing for hours a supervisee has not earned are universally accepted as unethical and are rarely practiced by the respondents to this survey. The third item, providing therapy to your student or supervisee, is considered never ethical by 40% of the respondents and has at sometime occurred for 27% of the respondents. The response rates are similar for the survey conducted by Pope et al. (1987). These response rates lead to the question: Under what circumstances is providing therapy or biofeedback to a student or supervisee ethical?

As the use of trainees and paraprofessionals increases, the need for continual training in ethical issues at the undergraduate level also increases. One way to begin to teach ethical awareness is for undergraduate programs to require ethical courses as a part of their programs. Another method is for the supervising professionals to offer ongoing education in ethical decision making. Most important is for the supervising professional to model appropriate ethical behavior

and ethical decision making. Regardless of the ethical awareness of trainees and paraprofessionals it is the ultimate responsibility of supervising professionals to assure the quality of care for all clients. One way to lighten this burden of responsibility is for supervising professionals to ensure that they and those they supervise receive proper on-going ethical education.

Problem and Controversial Items

Eight respondents made overall negative comments about the general attitude of the survey, with statements like:

> I disagree with the proposition that normative data can serve as a basis for ethical standards. As a diagnostic device to see how bad the problem is or as a tool to design remedial programs, it may have some value. The question about frequency of occurrence in practice is poor because these things are governed more by how frequently the person is presented with the opportunity to engage in the various acts than by how often he or she makes the right ethical decision.

Pope et al. (1987) warned against the use of normative data as the sole source of determining ethical codes. They argued that the standards established by ethical codes often serve to enhance the ethical awareness and behaviors of a professional organization even if they are only held by a minority of the professionals. Normative data on ethical beliefs and standards has typically been gathered in a forced choice manner. Surveys and questionnaires are sent to professionals which limit the ability of the professional to respond to all situational factors. For example, the majority of health-care professionals practice in urban areas, where buying goods and services from a client is considered unethical by a majority of professionals (Borys & Pope, 1989); yet for professionals practicing in a rural area this standard is difficult if not impossible to keep.

Normative data should probably not dictate the ethical codes of health-care professionals. Appropriate ethical decisions and ethical codes for health-care professionals may need to be modified according to the social climate, the geographical area, the goal of the work setting, and the findings from studies that demonstrate the impact of the behaviors of health-care professionals on the clients whom they serve. Normative data of the ethical beliefs and practices of health-care

professionals is one source of information about the social climate (Reese & Fremouw, 1984) and should be used in conjunction with other information in making ethical decisions.

Response patterns and comments made to four of the items on the current survey indicate that there may be some question concerning whether the questions were understood by the respondents. Five percent of the respondents declined to respond to the item, performing forensic work for a contingency fee, and 43% did not know or were not sure how to rate the behavior. It is very probable that very few biofeedback practitioners perform forensic work. It is also probable that the question was not understood. Discussing clients with other family members was also a misunderstood item. Twenty-three respondents made comments about this behavior and were unsure whether this meant discussion with the client's family members or with the professional's family members. Using self-disclosure as a treatment technique and performing custody evaluations without seeing both parents are items that are more oriented to psychotherapy and the largest single group of responses from AAPB members was in the "don't know/not sure" category. Such responding is probably an indication of the validity of the results obtained in that it is very probable that most biofeedback practitioners (especially non-psychologists) do not conduct custody evaluations or use extensive self-disclosure in doing biofeedback.

Controversial items are those items where less than 60% of the respondents agreed on the ethical standing of the behavior. There are 29 controversial behaviors. Many of these controversial issues for health-care professionals are behaviors that other professions take for granted as necessary practice. For example, shaking a client's hand, giving and accepting gifts from clients and attending social events with clients. These behaviors are less studied and the effects of these behaviors on the professional-client relationship are not known, yet these are the behaviors that professionals are faced with everyday. Further study is needed in these controversial areas in order for health-care professionals to better serve their clients.

General Comparison to Pope, Tabachnick, and Keith-Spiegel

In 1987, Pope et al. reported the results of the first questionnaire on general ethical beliefs and practices of psychologists. Eighty of the behaviors from that first survey were repeated with the current survey with very similar results. As can be seen in Figure 6 most of the differences in the two surveys are due to AAPB members responding "don't know/not Sure" whereas the sample used in 1987 had more definite opinions. This could be an artifact due to the nature of the survey and the populations used in each study or it could be an indication of changing ethical standards. Many of the items on the current survey are more appropriate for those professionals who practice psychotherapy. Since over 70% of the respondents from the current survey are from disciplines that use psychotherapeutic techniques (i.e., psychologists, counselors, and social workers) this may not be an issue for the majority of the respondents. For those respondents who do not use psychotherapy in their practice, it would be expected that they more often answer "don't know/not sure" to those items that are more appropriate for those who practice psychotherapy. This expected response pattern for the current survey can be seen when the overall response patterns from Pope et al. (1987) are compared to the overall response patterns on the current survey. The fact that respondents who are not as familiar with psychotherapy responded "don't know/not sure" with a higher frequency than respondents who are familiar with psychotherapy, can be used as a measure of validity, indicating that the respondents to the current survey read and thoughtfully responded to the questionnaire.

There are four items where the respondents from the current survey were substantially different from the respondents to the 1987 survey conducted by Pope et al. In 1987 the behavior "hugging a client" was considered always or often ethical by 45% of the respondents and never or rarely ethical by 45% of the respondents. In 1991, 60% of the respondents to the current survey reported that hugging a client is often or always ethical and only 23% believed the behavior to be never or rarely ethical. The results of the current survey are comparable to the results of a study conducted by Stake and Oliver (1991). This study rated hugging as 2.62 on a scale from 1 to 7

where 1 indicates that the behavior is never a misconduct and 7 indicates that the behavior is always a misconduct. The tendency may be to explain these results in terms of sample bias (i.e., biofeedback practitioners have a different type of relationship with their clients, making it more acceptable for them to hug clients), but given the results from Stake and Oliver, who sampled psychologists, the differences in response patterns may indicate a change in the ethical beliefs of health-care professionals.

Pope et al. (1987) reported that 71% of the respondents had raised their fee during the course of therapy while only 47% of the current respondents have engaged in a similar action. This response rate difference may be due to the tendency for biofeedback practitioners to serve clients over a shorter period of time. Eighty-seven percent of the 1987 respondents charged for missed sessions, while only 67% of the 1991 respondents charged for missed sessions.

The large number of behaviors that rarely or never occur in practice in both surveys, could be indicative of several circumstances. First, the opportunity for the behavior rarely or never occurs in practice. For example, situations such as being sexually attracted to a client, performing custody evaluations, or being invited to a client's social event may rarely occur so it is natural that these behaviors would rarely or never occur in practice (see Figure 7). Second, when a behavior that infrequently occurs in practice does occur, health-care professionals are less likely to know how to handle the behavior so they do nothing. For example, when health-care professionals learn of another health-care professional's misconduct, they might know that they should report the behavior; but due to the infrequency of this situation in their practice they may not know how to properly file a complaint so they do nothing. Third, even when health-care professionals believe a behavior is ethical, they may believe the behavior is optional and not practice the behavior for fear that complications may arise as a result of the behavior. For example, a health-care professional might feel that accepting goods or services rather than money for payment in a rural area is ethical practice; but due to the complications of determining the worth of the good or services may never practice this behavior. Fourth, the behavior may be too

inconvenient, time consuming, or stigmatizing for the professional to follow through. For example, many professionals will not take the time or go through the inconvenience of following through on ethical violations of their colleagues even when they know what they are supposed to do (Bernard et al., 1987; Bernard & Jara, 1986; Wilkins et al., 1990)

All the controversial items from both surveys are practiced rarely or never by more than 60% of the respondents. The trend to rarely or never practice controversial behaviors could be an indication that health-care professionals attempt to avoid questionable practices regardless of their beliefs. This type of behavior is encouraged by those who write about avoiding legal liability (Roswell, 1989), but the question of legal liability verses ethical conduct has not been addressed in the research literature.

Some of these items may be explained due to the cost or the time in completing the behavior (i.e., using a computerized testing service, establishing individual contracts for clients for services). Finally, research has shown that health-care professionals at times fail to follow through with behavior they know is ethical (Bernard et al., 1987; Wilkins et al., 1990). This raises the question that has not been answered in the research literature: Is it unethical not to practice an ethical behavior?

Special Issues in the Area of Confidentiality

The issue of confidentiality has long been a point of ethical concern for modern health-care professionals. Based on the available literature, confidentiality has been the most written about ethical issue with mental health-care professionals (see Table 3). With the controversy over the reporting of AIDS and other contagious diseases, confidentiality is a current on-going issue in other health-care professions. Since the Tarasoff case many practices surrounding the breach of confidentiality have been legally mandated and health-care professionals must abide by these mandates or face legal consequences (Corey et al., 1988). This may be one reason there are no controversial items in the confidentiality scale. Health-care professionals have been educated, out

of necessity, on socially and legally accepted practices in confidentiality and for the most part they abide by those standards. Confidentiality is a common issue for all biofeedback service providers.

Breaking confidentiality if the client is homicidal, suicidal or to report child abuse was universally accepted as ethical in the current survey. The results of the study by Pope et al. (1987) and Conte et al. (1989) indicate that breaking confidentiality if the client is homicidal is an acceptable behavior for at least 85% of the respondents. Breaking confidentiality to report child abuse was also a universally accepted behavior for the respondents from Pope et al. but was not mentioned by Conte et al. Breaking confidentiality if the client is suicidal was acceptable by 81% of the respondents from Pope et al. and 71% of the respondents from Conte et al. It is noteworthy that responses from the current survey and the survey by Pope at al. indicate even though a large majority of professionals believe these behaviors to be ethical, far fewer professionals actually practice these behaviors. Forty-three percent of the current respondents and 58% of the respondents from Pope et al. have on some occasion reported a homicidal client. Sixty-seven percent of the current respondents and 78% of the respondents from Pope et al. have, on some occasion, broken confidentiality with a suicidal client. Fifty-seven percent of the respondents from the current survey and 62% of the respondents from Pope et al. have on some occasion broken confidentiality to report child abuse. The differences in the occurrence of these behaviors between the two samples may be explained by the characteristics of the populations studied in each survey. The situations creating the need for these three behaviors probably occur rarely in the practice of most health-care professionals and probably occur even less frequently for health-care professionals who specialize in a treatment modality like biofeedback. Even though professionals believe these behaviors to be ethical they are rarely placed in a situation where they have to practice these behaviors.

There are two items from the confidentiality scale in the current survey and in the survey by Pope et al. (1987) that are universally accepted as unethical behavior. These behaviors are: unintentionally disclosing confidential information; and discussing a client, by name, with friends.

These two behaviors and the behavior of seeing a minor client without parental consent are rarely or never practiced by at least 85% of the current respondents and the respondents to the survey by Pope et al. (1987). The behavior of limiting treatment notes to name, date, and fee is also rarely practiced by the current respondents yet only 66% of the respondents from Pope et al. rarely or never practice this behavior. This difference may be explained by the fact that biofeedback practitioners would also want to keep a record of the client's physiological response patterns as part of the treatment notes where psychotherapists may not have this data to record.

There are three items on the confidentiality scale where the occurrence of the behavior is slightly greater than the reported ethical attitude indicates the behavior should occur. Forty-two percent of the respondents reported that it is never ethical to discuss clients, without names, with friends, yet only 34% of the respondents never engage in this practice. In essence, these results indicate that at least 10% of them violate client's rights in this area even though they know it is unethical. Sixty-eight percent of the respondents reported that it is never ethical to unintentionally disclose confidential information, yet only 50% report that this behavior never occurs. An indication that at least 18% of the respondents violate clients' rights in this area even though they know it is unethical to do so. Finally, 41% of the respondents report that discussing clients with other family members is never ethical, yet only 33% never practice this behavior. Again an indication that at least 8% of the respondents violate clients' rights in this area even though they know it is unethical to do so. This same response pattern is seen in the survey by Pope et al. (1987). One possible explanation for these results is that health-care professionals have not taken the issue of confidentiality seriously enough. Another explanation is that health-care professionals have not arranged for appropriate consultation, supervision, or peer reviews to work though confidentiality issues without involving people who have no need to know.

The treatment of clients in the health-care professions may be a stress-invoking experience. Like all humans who have undergone stressful experiences, health-care professionals have the need to reduce their stress. Debriefing is one method to reduce stress and consists of

talking about the experience with others. If health-care professionals do not create appropriate opportunities to debrief, they will continue to engage in these practices that they find unethical. Consultation with colleagues is a behavior that 96% of the respondents to the current survey believe is ethical, yet only 75% of the respondents report that they always or often engage in this behavior. For health-care professionals the development of appropriate debriefing is one essential step to avoid burnout and ethical violations (Greenburg, Lewis, & Johnson, 1985; Leiter & Meechan, 1986; Raquepaw & Miller, 1989). Debriefing can take place during regularly scheduled staff meetings or by setting up appropriate consultations with colleagues. It is also essential that clients are informed of professionals' debriefing methods and the reasons for debriefing and agree to these methods for protecting their rights of confidentiality.

Special Issues in the Area of Dual Relationships

Ethical issues dealing with dual relationships are an emerging area that is increasingly being studied and considered in the mental health-care professions. Dual relationships are the most expensive in terms of law suits brought against mental health-care professionals (Roswell, 1989). Based on the literature search, dual relationships is an area that has received very little attention in the professional literature of the other health-care professions (see Table 3), yet is beginning to receive increasing attention, especially in the area of client-professional sexual relations (Carr & Robinson, 1990). The area of dual relationships that is the most costly for professionals and clients is the area of professional-client sexual relations (Pope et al., 1987; Roswell, 1989). This survey covered professional-client sexual relations from fantasy to act.

The largest group of respondents, regardless of discipline, on the current survey (24%) did not know whether being sexually attracted to a client was ethical or not, while the largest group of respondents from Pope et al. (1987) (33%) believed that sexual attraction to a client is always ethical. Thirty percent of the respondents to the current survey reported that they have never been sexually attracted to a client, while only 9% of the respondents to Pope et al. reported

no sexual attraction. Thirty-nine respondents commented that the sexual feelings of a professional were neither ethical nor unethical. Although other surveys have asked how often sexual feelings toward clients occur in mental health-care professionals (Pope, Keith-Spiegel, & Tabachnick, 1986; Pope et al., 1987), the reports on these surveys have not mentioned any controversy surrounding the reported ethicalness of professionals' feelings. Generally, all feelings are natural and healthy and therefore ethical, as long as they are not acted out. When acted on, some behaviors associated with feelings are unethical. Being aware of and comfortable with personal feelings is the professional's first line of defense against the inappropriate actions that can be associated with any feeling toward a client including sexual feelings (Cormier & Cormier, 1985). The number of respondents to the current survey, who commented on the inappropriateness of asking questions about the sexual feelings of health-care professional, is an indication that health-care professionals are not comfortable with their feelings in this area and that they need education on what to do with these feelings when they have them. This opinion is shared by 16 of the respondents who made comments such as:

> Being sexually attracted to a client is not a problem if the clinician is not acting out those thoughts in any way. It is not unusual to have those feelings. What is essential is being conscious, responsible and being aware of one's own counter-transference.

Ninety-three percent of the respondents to the current survey reported that dressing seductively for a session with a client was always unethical and 89% reported they never engage in this behavior. Seventy-one percent of the respondents to the current survey reported that telling a client: "I'm sexually attracted to you" is never ethical and 98% report that they have never engaged in this behavior. Fifty-two percent of the respondents to Pope et al. (1987) reported that telling a client: "I'm sexually attracted to you" is never ethical and 79% report that they have never engaged in this behavior. The difference in this response rate may be explained by the differences in the populations used to obtain the samples for the respective surveys. Pope et al. (1987) used a sample of psychotherapists while responses to the current survey were obtained from a variety of health-care professionals who all practice or are interested in biofeedback. In

psychotherapy the discussion of feelings may be "grist" for the mill (Goldfried, 1982). In biofeedback the focus is on producing physiological changes; as such, unless biofeedback is combined with counseling or psychotherapy there would generally be much less discussion about other issues (e.g., sexual attraction of professional to client). The majority of respondents to the current survey may be involved in both biofeedback and psychotherapy (i.e., psychologists, social workers, counselors), yet 98% of the respondents never relate their sexual feelings to their clients. This pattern is similar to the results obtained in Pope et al. (1987). Most research on the subject of professional-client sexual relations finds that between 5 and 10% of health-care professionals at some time engage in sexual behavior with their clients (Carr & Robinson, 1990; Stake & Oliver, 1991). One of the best ways to control feelings is to talk about them, yet as evidenced from this and other research, most professionals set standards such that they cannot openly talk about and resolve feelings with those whom they are trying to help (Greenburg et al., 1985; Leiter & Meechan, 1986; Raquepaw & Miller, 1989; Snibbe, Radcliffe, Weisberger, Richards, & Kelly, 1989). Health-care professionals who conduct psychotherapy and counseling spend much time teaching their clients to be honest with their feelings, yet from the responses to this survey they do not seem comfortable modeling the same behavior. The goal in using any treatment technique is to benefit the client, yet health-care professionals often do their clients a disservice by avoiding uncomfortable issues. Professionals need to be aware of all of their feelings and be capable of dealing with their feelings in an appropriate and professional manner. Even professionals who are strictly practicing biofeedback or other objective interventions can subtly influence their clients' response through the type of interactions they have with their clients. These professionals also need to be aware of their feeling towards their clients, how those feelings might effect the way they behave toward their clients, and how those behaviors may influence the client's response to biofeedback and other objective intervention techniques.

Ninety-six percent of the respondents from the current survey and 95% of the respondents from Pope et al. (1987) report that they believe that it is never ethical to engage in erotic activity

with a client, yet 5 and 3%, respectively, admitted engaging in this behavior. Ninety-seven percent of the respondents from the current survey and 96% of the respondents from Pope et al. report that they believe it is never ethical to engage in sexual contact with a client and 96 and 97%, respectively, report that they have never engaged in this behavior. Sixty percent of the respondents from the current survey and 50% of the respondents from Pope et al. reported they believe that it is never ethical to become sexually involved with a former client and 91 and 88%, respectively, report that they have never engaged in this behavior. In a related behavior, 88% of the respondents to the current survey and 85% of the respondents to Pope et al. reported that they believe it is never ethical to become sexually involved with a clinical supervisee and 94 and 95%, respectively, report they have never engaged in this behavior.

These percentages are comparable to the results of other surveys conducted in this area. Stake and Oliver (1991) reported that most surveys find that between 5 and 10% of the respondents admit engaging in sexual contact with their clients. Borys and Pope (1989) reported that 98.7% of the respondents to their survey on dual relationships have never engaged in sexual activities with their clients. One hundred percent of the respondents to the survey by Conte et al. (1989) believe that sexual contact is unethical and 80% believe this conduct is grounds for malpractice.

The actual behavior of health-care professionals concerning their sexual activities with clients is a difficult area to study. Most survey results are an under reporting of what actually occurs (Pope et al., 1987; Stake and Oliver, 1991). Bouhoutsos, Holroyd, Lerman, Forer, and Greenburg (1983) conducted a study of 559 cases of intimate sexual behaviors between therapists and clients. They found that in the therapists' opinion, 90% of the clients suffered negative results from the sexual contact. Even though current social pressure, legislation, and the majority of health-care professionals have deemed professional-client sex as unethical, the debate still rages. One respondent (Ph.D. psychologist) to this survey commented:

> By making sexual contact between consenting adults who are therapist/client illegal seems to convey a message that the client in therapy is helpless and without responsibility - this

> is never true in life. Nonetheless, I believe sexual or erotic contact unethical and poor judgement and bad practice. I do however, recognize this as an ethical position which has developed. Few therapists would have held this position in the mid 1960's. Not so long ago! As a society I don't really believe that we've advanced so much in a generation!

Professionals through their professional writing continue to argue about whether client-therapist sexual relations are as damaging to the client as popular opinion reports it to be (Pope, 1990; Williams, 1990), and some health-care professionals argue that therapist-client sex is actually enjoyable and beneficial to the client (Herman, Gartrell, Olarte, Feldstein, & Localio, 1987). One respondent to this survey commented:

> Participation sexually is unethical, but providing sexually explicit materials or other techniques designed to educate (even through erotic) may be reasonable as part of sexual therapy. Same may be said of exploring a client's sexual fantasy, etc. - this can be ethical but erotic.

Although client-professional sexual relations are currently the most written about and the most costly in terms of insurance payments and litigation fees, there are other issues of interest regarding dual relationships. Offering or accepting a handshake from a client and allowing the client to address professionals by their first name are the only two behaviors from the dual relationship scale, that are universally accepted as ethical and often practiced by a majority of clients from both the current survey and from Pope et al. (1987). Other than the sexual behaviors mentioned above, only borrowing money from clients is universally accepted as unethical and rarely practiced by the respondents to the current survey and that of Pope et al. One reason for the overall acceptance or rejection of these behaviors could be that western social standards deem these behaviors appropriate professional courtesies. The impact these behaviors have on the fine line between professional relationships and social relationships while trying to provide the most efficient services to clients is an area that remains to be studied.

Sixteen (46%) of the 35 behaviors from the Dual Relationship scale meet the controversial criteria as defined in this paper, with a similar response pattern from Pope et al. (1987). Borys and Pope (1989) used a different set of 18 dual relationship behaviors and found that 8 (44%) meet the controversial definition. In each of the surveys all controversial items were

practiced rarely or never by over 60% of the respondents. One explanation of this response pattern may be that the situations requiring the professional to act on the controversial behaviors rarely occur in practice. Another explanation might be that health-care professionals avoid controversial behaviors because of the legal and social complications that may arise if they participate in these behaviors.

Special Issues in the Area of Professional Practice

The topic of professional practice has been written about in a philosophical and theoretical manner in the professional literature, especially medical literature, yet there are no research studies that have specifically targeted professional practice (see Table 3). This is puzzling given the current public debate on professional practice issues such as availability of services and cost of services (Freiburg, 1991; Youngstrom, 1991a; Youngstrom, 1991b).

Thirty-five percent of the items on the professional practice scale from the current survey are agreed upon by less than 60% of the respondents with a similar pattern from Pope et al. (1987). The large number of controversial items from the professional practice scale could be due to the lack of knowledge about these behaviors due to the infrequency which they occur in the professional's practice, the lack of clear ethical standards in this area, or it could be that the issues of professional practice are more directly related to the circumstances surrounding the ethical dilemma, than are the issues of confidentiality and dual relationships. For example, principle 5 under that heading "Responsibility" in the AAPB code of ethics states:

> All practitioners realize that their professional activities with clients may result in changes in the lives of those clients and others. As such, practitioners guard against misuse of their influence and actions. (AAPB, 1990, p.2)

There is a similar statement in APA's "Ethical Principles of Psychologists" (1990):

> As practitioners, psychologists know that they bear a heavy social responsibility because their recommendations and professional actions may alter the lives of others. They are alert to personal, social, organizational, financial, or political situations and pressure that might lead to misuse of their influence. (p. 390)

Typically clients seek out health-care professionals because they want a change in their lives. It is extremely difficult, if not impossible, for health-care professionals to offer value-free services (Corey et al., 1988). In essence, whenever health-care professionals provide services for clients they are influencing their clients based on their personal values. The question as to what is an appropriate use of influence in helping the client change and what is a misuse of influence is not defined in the above ethical principles nor is it a question that has been answered in the professional literature.

The following is an example of how situational differences may influence ethical decisions in professional practice: Is allowing an affluent client to run up a large unpaid bill ethically different from allowing a client whose income is below the poverty level to run up a large bill? These specific questions concerning professional practice behaviors have yet to be asked.

Pope (1990) describes the ethical clash between the professional practices of psychologists and the administrations of non-traditional psychological settings such as hospitals and insurance companies. Yet, the results of the current survey make clear that there are no differences in the ethical beliefs or practices of the health-care professionals who work in those settings. With the increase in the use of multidisciplinary teams in the health-care professions, clashes such as those described by Pope (1990) are likely to continue. To reduce the organization's liability, insurance companies and administrators are developing and presenting workshops and inservice training on risk management. The recommendations from these presentations may or may not be within the health-care professional's ethical guidelines. For example, one presentation recommends conducting therapy sessions with the door open so office staff and other clients can verify what occurred in the office during treatment (MHRRG, 1990). This procedure may violate the client's rights to confidentiality and may make it difficult to develop professional-client trust. One possible solution is for health-care professional organizations to work together in creating and implementing ethical education for administrators and insurance companies.

Another solution to the conflict between health-care professionals and administrators over ethical behaviors is the on-going study of what those behaviors are and the impact those behaviors have on clients. Insurance companies and administrators often make decisions based on actuarial data not personal philosophies (Dawes, Faust, & Meehl, 1989). Based on administrative and insurance decision making policies, health-care professions need data to support their ethical positions if they are to prevent insurance companies and administrative policies from dictating their ethical practice.

Limitations

This was a systematic replication study, a first attempt at partially replicating the 1987 study of the ethical beliefs and practices of psychologists by Pope et al. with a different subject population and a somewhat different pool of items. This study expands on Pope's study by comparing the reported ethical beliefs and practices of various health-care professionals across professions. Due to the size and type of sample, caution should be used in interpreting the results. The current survey only had a response rate of 26% with information coming only from AAPB members who completed and returned the survey. Even though the responses represent 26% of the population and that the demographic characteristics of the sample closely match the population, no data was gathered on the characteristics of the non-respondents. Second, only members of the Association for Applied Psychophysiology and Biofeedback (AAPB) were selected as subjects. AAPB members are a highly heterogeneous group of health-care professionals and are encouraged to abide by the ethical standards of their own disciplines, yet they all have a common interest in psychophysiology and biofeedback and are required to abide by AAPB's ethical principles, which are based on the ethical principles of the American Psychological Association. Caution must be used when generalizing the results from a sample with specific characteristics (i.e., interest in biofeedback) to populations that may or may not have those characteristics. Third, reported ethical beliefs and practices may not accurately portray the actual

ethical beliefs and practices of the population (Borg & Gall, 1989; Pope et al., 1987). Fourth, due to the diversity in the respondents' disciplines and areas of professional practice, many respondents may not have had experience with professional procedures and other ethical considerations in areas such as performing forensic work or custody evaluations. Lack of experience in an area represented by a given item was not controlled in this study and as such may limit generalizability when comparing the results to populations who specialize in the given area. Fifth, as this was a truly anonymous survey, it was impossible to conduct follow-up mailings or to account for the characteristics of the non-respondent, which is a limiting factor in interpreting the results.

Face Validity of the Survey

Although there are no statistical validity measures available on the questionnaire used in this survey, there are several indications of the survey's validity. The survey was pretested with a small sample (n=5) of psychology graduate students. From this pretest it was determined that it would take about 30 minutes to complete the survey. Based on respondents' comments, many individuals took up to three times that long, a possible indication that most respondents carefully read and answered each item. Another indication of face validity is the overall response pattern. As was expected, based on the results of the general ethical survey conducted by Pope et al. (1987) items that are considered always ethical but rarely occur (i.e., reported a colleague for an ethical violation, breaking confidentiality to report a possible homicide, etc.) would have a high percentage of responses in the often and always ethical categories with corresponding high percentages in the never and rarely occurs categories. Some items on the survey did not neatly fit the biofeedback population used to collect the data. As such it would be expected that this sample would have a higher rate of responses in the "don't know/not sure" category. As has been demonstrated this is the case, thereby indicating that the respondents responsibly read and responded to the survey items.

Importance of the Current Study

The major importance of the current study is to provide normative data to health-care professionals that they can use as one source of information in helping them make ethical decisions. By knowing the ethical beliefs and practices of other health-care professionals it is possible for individual professionals to make better informed decisions when faced with ethical dilemmas.

For various reasons, psychologists are beginning to move their practices into non-traditional settings, such as hospitals (Pope, 1990). As a result, health-care professionals from differing disciplines more often working together in the same setting and on interdisciplinary treatment teams. The most significant finding of this study is that, gender differences aside, and contrary to popular opinion, health-care professionals have basically the same ethical beliefs. Practicing health-care professionals can use this knowledge in establishing ethical criteria and procedures for all members of multidisciplinary teams.

The trend for less educated professionals to be more conservative in their ethical beliefs and practices is important knowledge for professional training centers and continuing education programs. With the increase in the number of lawsuits being brought against professionals, training programs should take another look at their level of training in ethical decision making. The need for more and/or better ethical education, especially in the lower levels of training, means that those writing textbooks and developing workshops should devote more time to the discussion of ethical issues.

Professional organizations require that their members follow their code of ethics, and some licensure and certification standards require that professionals have ethical training before they can be licensed or certified (BCIA, 1991), yet as many of the items on this survey, ethical codes and ethical training are often presented in a vague manner. This vagueness may be an attempt to allow professionals the latitude they need to make appropriate ethical decisions based on the client's needs and the situational demands, but it may also serve to hinder the professionals'

ability to make knowledgeable decisions. Given that ethical codes expect professionals to translate vague standards into specific behaviors, it is interesting that well over 50% of the comments on specific items were that the items were too vague to be able to make competent ethical decisions. Currently, the American Psychological Association is revising their ethical codes to be less vague and more specific. Based on the comments and response style of the participants to this survey, this is a trend that all professional organizations should follow.

Perhaps the most important contribution of this survey was that the membership of AAPB was given the opportunity to reexamine their personal ethical beliefs and practices. With the number of malpractice and other law suits increasing yearly, it is important that health-care professionals continually reexamine and modify their ethical beliefs and behaviors to protect themselves and the clients whom they serve.

Questions for Further Research

The results of this survey indicate that practicing health-care professionals have basically the same ethical beliefs and practices on the behavior items questioned. As an initial study comparing the ethical beliefs and behaviors of a wide range of health-care professionals the greatest need for future research is refinement and replication of the current study on the general ethical beliefs of health-care professionals. Fifty percent of the respondents who made comments about the current questionnaire qualified their responses by giving examples that they believed supported their response. Given this concern for situational differences, whole studies could be designed to see if there are actually situational differences and if so, what are the necessary components of a situation that make a normally unethical behavior ethical?

The current questionnaire consisted of 99 behavior items. This is a small sampling of ethical behaviors. Future studies should include behaviors that were not questioned in this study. Some of the respondents to the current survey suggested five other specific areas that they would like to see added to future studies in this area. First, what are the ethical issues involved in

training professionals to conduct biofeedback? Second, what are the ethical issues in using video or audio taped instructions for clients? Third, what are the ethical issues involved in using medical gowns and in the placement of electrodes on the trapezia? Fourth, is it ethical to hire a client or former client? Finally, is it ethical to provide biofeedback services without being certified in biofeedback?

The trend of less educated professionals responding in a more polarized manner on controversial items was unable to be full analyzed in this study. Future studies on the reported ethical beliefs and behaviors of health-care professionals should collect data on: a) years of education; and b) number of ethical workshops or courses attended. This data would better enable future studies to determine if education does make a difference on ethical beliefs.

The results of the "occurrence in practice" scale are difficult to interpret as there is no baseline available on how often opportunity for the questioned behavior occurs in practice. For example, 2% of the current respondents rarely engage in sexual contact with a client. Does this mean that these professionals rarely take advantage of the opportunity to engage in sexual contact with a client; or do they always take advantage of these situations, but the situations rarely occur in their practice? Future studies could improve on this survey by asking the respondents to provide baseline data on how often the opportunity to engage in the questioned behavior occurs in their practice.

Based on the results of this study, many professionals for whatever reasons do not always behave according to their ethical beliefs. An important question that this study did not address but that needs to be examined is: If a behavior is considered ethical, is it unethical not to engage in that behavior when the opportunity arises? For example, using written informed consent procedures are considered often or always ethical by 92.9% of the respondents, yet only 70.4% of the respondents often or always use written informed consent. Are 22.5% of the respondents behaving in an unethical manner by not using written informed consent? Is verbal informed consent just as ethical and only the highly cautious professionals use written informed consent as a

risk management technique to avoid law suits and to communicate with clients? Another example is the behavior of revising treatment plans regularly. Ninety-four percent of the respondents reported that revising treatment plans regularly is often or always ethical, yet only 79% often or always engage in this behavior. Is there another ethical option that makes it okay for these professionals to not regularly revise treatment plans or are 15% of the professionals who responded to this survey behaving in an unethical manner. These types of questions have not been asked in any study on the ethical beliefs or practices of health-care professionals about behaviors that are considered ethical yet are not practiced.

Significant gender differences were found in the responses to this survey. Interesting research could be conducted to try and determine the source of these differences. Perhaps more important for health-care professionals would be research on the impact of these gender differences on the quality of services provided to clients, the welfare of the client, and on professional issues such as professional burn-out and career advancement.

The current study showed a trend whereby respondents with less formal education tended to be more polarized in their ethical beliefs on controversial items. Future studies in the area of ethics should collect detailed data on the respondents professional education and specifically on their ethical education.

Finally, if the ethical beliefs and practices of health-care professionals from different disciplines are the same, what is the source of the issues that complicate the development and efficient use of multidisciplinary teams as described by Pope (1990)? Are these complicating factors due to professional jealousies between the professions, the drive of the professional to gain power within an organization, the individual standards of the professionals who are working together, or due to the administrative policies of the service agencies? The question of what role the administrative style of the agency has in complicating the development and efficient use of multidisciplinary teams could either be studied by comparing agency policies against the reported beliefs and practices of professionals working in the agency or by comparing agency policies to

the professional codes of ethics established by the professional organizations that serve health-care professionals.

Conclusion

It seems that in the area of ethics, health-care professionals rely on their personal philosophical beliefs and clinical judgments in determining their ethical standards and that in many cases their personal beliefs leave them unprepared to competently make ethical decisions. Ethical attitudes and opinions are an area that receives much attention in professional literature, yet as seen from this survey, attitudes and opinions do not always translate into like behavior. Professional organizations create ethical codes to protect the welfare of the client and the professional, and attempt to avoid restrictive government regulations, yet if the ethical codes are not followed they fail in this purpose. The only way to determine if ethical codes are useful is through the continual study of ethical beliefs and practices.

Normative data of ethical beliefs and practices of helping professionals should not serve as the sole source of information in determining ethical codes. In making appropriate ethical decisions and creating ethical codes, health-care professionals need to be sensitive to the social climate, the geographical area, the goal of the work setting, and studies that demonstrate the impact of professional behavior on clients. Most importantly, health-care professionals must keep the welfare of their clients first and foremost in their minds when making ethical decisions.

From all the data presented previously, ethical beliefs and practices are continually changing. Behaviors that were common five years ago are currently less practiced while other behaviors are increasing. If health-care professionals do not keep up with the zeitgeist of the times in ethical behaviors they are setting themselves up for law suits and other repercussions. The health-care professionals who responded to this survey answered "I don't know" to a relatively large proportion of behaviors when asked: "How ethical is this behavior?" Health-care professionals should continually be expanding their knowledge base to make the best decisions

when faced with an ethical dilemma. One source of knowledge is normative data, a source that has been overlooked in the past.

Currently, the APA is undergoing a revision of their ethical practices, a revision that has taken six years and is not complete (APA, 1991). If "ethics" had been "a study of moral behavior" instead of a philosophy of moral behavior, then APA's ethics committee may have been able to respond more efficiently to the call for a revision of their ethical codes. If health-care professionals expect to govern their own behaviors through ethical codes and principles, there should be on-going studies of the beliefs and behaviors of health-care professionals and on the impact that those beliefs and behaviors have on the clients served.

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APPENDICES

APPENDIX (A)

Questionnaire

Cover Letter

Dear AAPB Member:

I need your help in collecting information on the ethical beliefs and practices of AAPB members. It will take about 30 minutes of your time to help me and yourself by completing the enclosed questionnaire. The enclosed questionnaire is concerned with the ethical beliefs and practices of helping professionals working in psychophysiology and biofeedback. With the continuing rise in the number of ethical complaints and malpractice suits against helping professionals it is important that we expand our knowledge of the actual beliefs and behaviors of practicing professionals and not let theoretical discussions or the inappropriate actions of a few helping professionals govern the regulations that are placed on our professional behavior through ethics codes and laws.

Your response to this questionnaire will help to build a knowledge base of the actual ethical behaviors and practices of AAPB members. When faced with an ethical dilemma you will be able to use this knowledge base as one source to help make more informed choices. AAPB and BCIA should be able to use this knowledge base in examining their current ethical codes, licensure and/or certification standards and begin to determine where changes need to be made and what areas need to be clarified through continuing education. Training centers will be able to use the date to strengthen their curriculum in ethical education. To maintain confidentially all responses to this questionnaire will be anonymous. You are asked to complete the demographic information and respond to the questionnaire items without revealing any personal identifiers. It will be appreciated if you will complete this questionnaire prior to December 15, 1990 and return it in the stamped envelope enclosed. I welcome any comments you may have concerning any of the items on the questionnaire or any area of ethical concern you feel have not been covered. The results of the survey will be submitted for publication in The Journal of Biofeedback and Self Regulation or in the Biofeedback Newsletter. Won't you please help me acquire some needed information on ethical beliefs and practices by completing the questionnaire now. Thank you for your cooperation.

Sincerely yours,
Sebastian Striefel
Treasurer AAPB
Professor of Psychology

Section I: Demographic Information

Please complete the following information about yourself by circling or filling in the appropriate response in each category.

1. Highest Educational Degree and Discipline of Degree:

Degree	Discipline	
Ph.D	Psychology	Dental
M.D.	Medical (including Psychiatry)	Physical Therapy
Ed.D.	Occupational Therapy	Chiropractic
M.S.	Nursing	Social Work
M.A.	Counseling	Education
B.S.	Speech Pathology	Other (Specify)__________
B.A.		
High School Diploma		
Other (Specify)__________		

2. List your job title: ____

3. Primary work setting:

Private Practice	Clinic
Hospital/Institution	University/Academic
Grade School	Other (Specify)__________

4. Licensed in Professional discipline: YES NO
5. Certified by BICA in Biofeedback: YES NO
6. Years of practice in professional discipline: ____
7. Years of practice in biofeedback: ____
8. Age: ______
9. Sex: ______

Section II: Behavior Questionnaire

Read each of the behaviors listed below and determine, how ethical you consider this behavior to be, then code the behavior as (1) never ethical, (2) rarely ethical, (3) don't know/not sure, (4) often ethical, (5) always ethical. The coding is accomplished by marking the space under the appropriate number in the column labeled "Ethical?". Next, determine how often the behavior occurs in your practice or work setting (column labeled "Occurrence in practice?") and code each behavior as (1) never occurs, (2) rarely occurs, (3) sometimes occurs, (4) occurs fairly often, (5) occurs very often. For example, if the first behavior was "Shaking hands with your client" and you determine that this behavior is unquestionably ethical and occurs all the time, then you would code the behavior as shown below.

Example:

Behavior	Ethical?					Occurrence in practice?				
	1	2	3	4	5	1	2	3	4	5
1. Shaking hands with your client	||	||	||	||	||	||	||	||	||	||

Ethical Beliefs and Practices - Questionnaire

	Ethical?*					Occurrence in practice?**				
	1	2	3	4	5	1	2	3	4	5
1. Becoming social friends with a former client	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
2. Charging a client no fee for therapy	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
3. Providing therapy to one of your friends	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
4. Advertising in newspapers or similar media	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
5. Limiting treatment notes to name, date, and fee	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
6. Filing an ethics complaint against a colleague	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
7. Telling client you are angry at him or her	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
8. Using a computerized test interpretation service	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
9. Hugging a client	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
10. Terminating therapy if the client cannot pay	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
11. Accepting services from a client in lieu of fee	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
12. Seeing a minor client without parental consent	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
13. Having clients take tests (e.g., MMPI) at home	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
14. Altering a diagnosis to meet insurance criteria	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
15. Telling client: " I'm sexually attracted to you."	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
16. Refusing to let clients read their chart notes	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
17. Using a collection agency to collect late fees	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
18. Breaking confidentiality if client is homicidal	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
19. Performing forensic work for a contingency fee	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
20. Using self-disclosure as a therapy technique	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
21. Inviting clients to an office open house	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
22. Accepting a client's gift worth at least $50	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
23. Working when too distressed to be effective	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
24. Accepting only male or female clients	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
25. Not allowing client access to testing report	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
26. Raising the fee during the course of therapy	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
27. Breaking confidentiality if the client is suicidal	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
28. Not allowing clients access to raw test data	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
29. Allowing a client to run up a large unpaid bill	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
30. Accepting goods (rather than money) as payment	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
31. Refusal to treat clients with AIDS	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
32. Breaking confidentiality to report child abuse	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
33. Inviting clients to a party or social event	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
34. Addressing the client by his or her first name	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
35. Engaging in erotic activity with a client	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
36. Using individualized treatment plans	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
37. Asking favors (e.g., a ride home) from clients	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
38. Making custody evaluation without seeing the child	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
39. Accepting the client's decision to commit suicide	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
	1	2	3	4	5	1	2	3	4	5
	Ethical?					Occurrence in practice?				

*How ethical is this behavior?
(1) never ethical, (2) rarely ethical, (3) don't know/not sure, (4) often ethical, (5) always ethical

**How often does the behavior occur in your practice?
(1) never occurs, (2) rarely occurs, (3) sometimes occurs, (4) occurs fairly often, (5) occurs very often

Ethical Beliefs and Practices - Questionnaire (cont.)

	Ethical?*					Occurrence in practice?**				
	1	2	3	4	5	1	2	3	4	5
40. Refusing to disclose a diagnosis to a client										
41. Revising treatment plans regularly										
42. Telling clients of your disappointment in them										
43. Discussing clients (without names) with friends										
44. Providing therapy to your student or supervisee										
45. Giving gifts to those who refer clients to you										
46. Using a law suit to collect fees from clients										
47. Becoming sexually involved with a former client										
48. Avoiding certain clients for fear of being sued										
49. Doing custody evaluation without seeing both parents										
50. Lending money to a client										
51. Providing therapy to one of your employees										
52. Having a client address you by your first name										
53. Sending holiday greeting cards to your clients										
54. Kissing a client										
55. Obtaining only verbal permission to treat client										
56. Giving a gift worth at least $50 to a client										
57. Accepting a client's invitation to a party										
58. Engaging in sex with a clinical supervisee										
59. Going to a client's special event (e.g., wedding)										
60. Getting paid to refer clients to someone										
61. Going into business with a client										
62. Engaging in sexual contact with a client										
63. Utilizing involuntary hospitalization										
64. Selling goods to a client										
65. Giving personal advise on radio, t.v., etc.										
66. Being sexually attracted to a client										
67. Unintentionally disclosing confidential information										
68. Allowing a client to disrobe in your presence										
69. Borrowing money from a client										
70. Discussing a client (by name) with friends										
71. Providing services outside areas of competence										
72. Signing for hours a supervisee has not earned										
73. Treating homosexuality per se as pathological										
74. Doing therapy while under the influence of alcohol										
75. Engaging in sexual fantasy about a client										
76. Accepting a gift worth less than $5 from a client										
77. Offering or accepting a handshake from a client										
78. Disrobing in the presence of a client										
	1	2	3	4	5	1	2	3	4	5
	Ethical?					Occurrence in practice?				

*How ethical is this behavior?

(1) never ethical, (2) rarely ethical, (3) don't know/not sure, (4) often ethical, (5) always ethical

**How often does the behavior occur in your practice?

(1) never occurs, (2) rarely occurs, (3) sometimes occurs, (4) occurs fairly often, (5) occurs very often

Ethical Beliefs and Practices - Questionnaire (cont.)

	Ethical?* 1	2	3	4	5	Occurrence in practice?** 1	2	3	4	5
79. Charging for missed appointments	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
80. Going into business with a former client	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
81. Directly soliciting a person to be a client	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
82. Being sexually attracted to a client	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
83. Helping a client file a complaint about a colleague	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
84. Telling clients what they should do	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
85. Explaining biofeedback process before treatment	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
86. Continuing to see clients for treatment when treatment goals have been reached	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
87. Continuing services to a client when the client is no longer receiving any benefits	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
88. Clearly defining criteria for determining whether client is benefiting from services	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
89. Establishing individual contracts with clients for services	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
90. Deceiving clients for their own good	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
91. Using the same biofeedback instructions for all clients	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
92. Dressing seductively for sessions with clients	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
93. Paying undue attention to client's dress and appearance	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
94. Crying in the presence of a client	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
95. Consultation with colleagues on regular basis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
96. Using written informed consent procedures	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
97. Terminating services to a client because you are sexually attracted to them	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
98. Keeping updated on ethical principles and state laws that effect your practice of biofeedback	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
99. Discussing clients with other family members	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
	1	2	3	4	5	1	2	3	4	5
	Ethical?					Occurrence in practice?				

*How ethical is this behavior?

(1) never ethical, (2) rarely ethical, (3) don't know/not sure, (4) often ethical, (5) always ethical

**How often does the behavior occur in your practice?

(1) never occurs, (2) rarely occurs, (3) sometimes occurs, (4) occurs fairly often, (5) occurs very often

Comments:

APPENDIX (B)

Breakdown of Questionnaire Items by Category

Breakdown of Questionnaire Items by Category

Dual Relationships

1. Becoming social friends with a former client.

3. Providing therapy to one of your friends.

7. Telling a client you are angry at him or her.

9. Hugging a client.

11. Accepting services from a client is lieu of fee.

15. Telling client: "I'm sexually attracted to you."

21. Inviting clients to an office open house.

22. Accepting a client's gift worth at least $50.

30. Accepting goods (rather than money) as payment.

33. Inviting clients to a party or social event.

35. Engaging in erotic activity with a client.

37. Asking favors (e.g., a ride home) from clients.

44. Providing therapy to your student or supervisee.

47. Becoming sexually involved with a former client.

50. Lending money to a client.

51. Providing therapy to one of your employees.

52. Having a client address you by your first name.

53. Sending holiday greeting cards to your clients.

54. Kissing a client.

56. Giving a gift worth at least $50 to a client.

57. Accepting a client's invitation to a party.

58. Engaging is sex with a clinical supervisee.

59. Going to a client's special event (e.g., wedding).

61. Going into business with a client.

62. Engaging in sexual contact with a client.

64. Selling goods to a client.

66. Being sexually attracted to client.

69. Borrowing money from a client.

75. Engaging in sexual fantasy about a client.

76. Accepting a gift worth less than $5 from a client.

77. Offering or accepting a handshake from a client.

80. Going into business with a former client.

82. Being sexually attracted to a client.

92. Dressing seductively for sessions with clients.

93. Paying undue attention to client's dress and appearance.

Professional Practice

2. Charging a client no fee for therapy.

4. Advertising in newspapers or similar media.

6. Filing an ethics complaint against a colleague

8. Using a computerized testing service.

10. Terminating therapy if the client cannot pay.

13. Having clients take tests (e.g., MMPI) at home.

14. Altering a diagnosis to meet insurance criteria.

16. Refusing to let clients read their chart notes.

19. Performing forensic work for a contingency fee.

20. Using self-disclosure as a therapy technique.

23. Working when too distressed to be effective.

24. Accepting only male or female clients.

25. Not allowing clients access to testing report.

26. Rasing the fee during the course of therapy.

28. Not allowing clients access to raw test data.

29. Allowing clients to run up a large unpaid bill.

31. Refusal to treat clients with AIDS.

34. Addressing the client by his or her first name.

36. Using individualized treatment plans.

38. Making custody evaluations without seeing the child.

39. Accepting the client's decision to commit suicide.

40. Refusing to disclose a diagnosis to a client.

41. Revising treatment plans regularly.

42. Telling clients of your disappointment in them.

45. Giving gifts to those who refer clients to you.

46. Using a law suit to collect fees from clients.

48. Avoiding certain clients for fear of being sued.

49. Doing custody evaluations without seeing both parents.

55. Obtaining only verbal permission to treat client.

60. Getting paid to refer clients to someone.

63. Utilizing involuntary hospitalization.

65. Giving personal advise on radio, T.V., etc.

68. Allowing a client to disrobe in your presence.

71. Providing services outside areas of competence.

72. Signing for hours a supervisee has not earned.

73. Treating homosexuality per se as pathological.

74. Doing therapy whole under the influence of alcohol.

78. Disrobing in the presence of a client.

79. Charging for missed appointments.

81. Directly soliciting a person to be a client.

83. Helping a client file a complaint about a colleague

84. Telling clients what they should do.

85. Explaining biofeedback process before treatment.

86. Continuing to see clients for treatment when treatment goals have been reached.

87. Continuing services to a client when the client is no longer receiving any benefits.

88. Clearly defining criteria for determining whether client is benefiting from services.

89. Establishing individual contracts with clients for services.

90. Deceiving clients for their own good.

91. Using the same biofeedback instructions for all clients.

94. Crying in the presence of a client.

95. Consultation with colleagues on regular basis.

96. Using written informed consent procedures.

97. Terminating services to a client because you are sexually attracted to them.

98. Keeping updated on ethical principles and state laws that effect your practice of biofeedback.

Confidentiality

5. Limiting treatment notes to name, date, and fee.

12. Seeing a minor client without parental consent.

17. Using a collection agency to collect late fees.

18. Breaking confidentiality if the client is homicidal.

27. Breaking confidentiality if the client is suicidal.

32. Breaking confidentiality to report child abuse.

43. Discussing clients (without names) with friends.

67. Unintentionally disclosing confidential information.

70. Discussing a client (by name) with friends.

99. Discussing clients with other family members.