PSYCHOTHERAPISTS' ATTITUDES AND PRACTICES REGARDING SEXUAL INTIMACY WITH CLIENTS

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By
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ABSTRACT

A study was designed to assess the attitudes and practices of psychiatrists and psychologists regarding nonerotic and erotic contact with their patients. A dual aim was to determine if there was a relationship between the attitudes involving contact with patients and the actual practices of the psychiatrists and psychologists.

Data were collected, with the use of a questionnaire, from a group of psychiatrists and psychologists on the variables of: the belief in, and the utilization of nonerotic contact with patients in a therapy practice; the belief in, and the utilization of erotic contact with patients in a therapy practice; and whether both types of contact could be misunderstood by the patient.

In a survey of the population of psychiatrists and psychologists of Palo Alto, California, it was found that their practices regarding nonerotic and erotic contact with patients were significantly, positively correlated with the attitudes regarding nonerotic and erotic contact with patients. The variables of age, marital status, gender, and the years in practice did not contribute to differences in psychotherapists' attitudes and in their practices of either nonerotic and erotic contact with patients. It was further concluded that of the psychotherapists that responded in Palo Alto, California, intimacy between therapist and patient was quite uncommon.
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Chapter I
INTRODUCTION

The objectives of the present study are (1) to assess the attitudes of psychiatrists and psychologists regarding erotic and nonerotic contact with their patients, and (2) to examine the relationship between such attitudes and the actual practices of the psychiatrists and psychologists.

Nonerotic contact is behavior such as hugging, kissing and touching, when the intent of such acts is nonsexual. Erotic contact is any contact that is primarily intended to arouse or satisfy sexual desire.

The effects of this process as experienced by the client will not be addressed in the present study. Instead the research undertaken is intended to clarify the attitudinal factors effecting the psychotherapist in attempting to make these distinctions.

There is a need for an honest exploration of the ethical, moral and therapeutical issues involved in the psychotherapeutic relationship. This need is reflected in the lack of significant literature and research regarding intimacy between psychotherapists and their patients. Moreover, there is a lack of open discussion regarding intimacy between psychotherapists and their patients. "Where there is not fact, fantasy and fallacy flourish" (Kardener, 1973, p. 1077).
Researchers that have attempted to explore this area have found that contact between patient and psychotherapist does occur. The majority of contacts between patient and psychotherapist are traditional, professional relationships. However, there are a small but significant number of contacts that do lead to sexual intimacy. It is estimated that one in five psychotherapists will become intimate with their patients (Butler & Zelen, 1977).

Consequently, as a result of the cultural forces of sexual repression, the lines of conduct between psychotherapist and patient are blurred. The cultural taboos in our society discourage discussion regarding sexual matters. These taboos become even more complex when the sexual relationship involves the psychotherapist and his/her patient. Is the therapist, who is subject to the same cultural forces of sexual repression as is the patient, prepared to be of help? The long standing cultural taboos regarding discussion of sexual matters, helps to maintain an idealized image of the therapist. The fact that the role of the therapist grew out of the priest-practitioner heritage, and the rampant ignorance due to the lack of research, have contributed to the maintenance of mythology in all matters sexual (Kardener, 1973).

When the therapeutic transaction involves the preceding factors, the questions that must be clarified become: Is the psychotherapist able to distinguish between care and comfort for the patient or else transgress into an act that
is antitherapeutic? Moreover, is the psychotherapist able to follow the ethical and moral obligations to make that distinction?

Background of the Problem

Sexual intimacy between therapist and patient has generally been viewed as incompatible with medical and psychological ethics. At the same time, intimacy between therapist and patient has been a historic concern. Hippocrates was the first practitioner to formally present his concern: "...Every house I shall only enter for the sake of my patients' wellbeing, refraining from every intentional harm and all seduction, especially from love relationships with women or men, be they free or bonded" (Van Emde Boas, 1966, p. 215).

Our culture has undergone a great many changes. The open and expressive culture of today with its relaxed sexual mores is considerably different from the culture of Hippocrates when he stated the guidelines for medical conduct. The latter position is quite compatible with the constricted role of the psychotherapist developed by Freud. Present developments in the field of psychotherapy have progressed from Freud's strictly psychoanalytic view of the therapeutic process to a more humanistic approach. When the humanistic perspective is placed within the present culture it embodies the characteristics of a more expressive and open psychotherapy. The role that has changed from the ideal presented by Freud of a "blank
mirror", with the therapist seated behind the client, to a therapist who is seated directly facing the client utilizing a considerable amount of self-expression in the therapeutic interview.

Reasons for the development and change in psychotherapeutic theories and for the change in roles of the psychotherapist can be attributed to many factors: (1) a greater emphasis and increase of research (e.g., a constant search for a better way), (2) changes in society (e.g., a greater permissiveness, a relaxation of ethics and morals), and (3) intrapersonal changes (e.g., the alienation of man in society which contributes to greater striving for increased intimacy in all aspects of the societal spectrum).

The changes in our culture and in society's attitudes, have yet to influence formalized changes regarding the role of the psychotherapist. The extremely moral and ethical context within which the psychotherapist is placed makes it difficult for these changes to occur. Additionally, the guidelines of the Hippocratic and professional ethics to which the psychotherapists must adhere make it difficult for changes in behavioral modes to be researched.

Due to the controversy that this subject presents, a major aim of research has been simply to present the topic as a concern that involves medical and psychotherapeutic practices. With the increasing evidence that sexual intimacy does exist between the psychotherapist and patient, there
have been attempts to gather data regarding the positions and beliefs of the psychotherapists with regard to the topic. The professional limitations and the public repercussions from attempts at investigation of the topic have contributed to the small amount of research on this subject. These factors, coupled with the limitations and repercussions that the psychotherapists must face in voicing their own opinions regarding contact with their patients, present an almost unrelenting shield. Applications of these factors to the present study may influence the collection of data. Van Emde Boas (1966) suggested that researchers are "dealing here with a matter about which the very person who could supply these data are wise enough to keep silent" (p. 215).

The suggestion of professional and public recriminations have contributed to a universal opinion that intimacy does not occur between therapist and patient. Moreover, if intimacy is said to have occurred (by a patient to another therapist) the first reactions are: (1) that it is fantasy, or (2) proof of positive transference. Reasons for the widely held rationale according to Van Emde Boas (1966) are "due to group narcissism and good fellowship" (p. 215).

In light of the conditions and limitations encompassing this area of research, an attempt will be made at assessing the attitudes and practises of psychiatrists and psychologists regarding sexual intimacy with their patients.
Significance of the Problem

Masters and Johnson (1966) noted the incidences of sexual intimacy between therapist and patient almost fifteen years ago. At that time Masters called for a "Kinsey type of survey" to bring this controversial topic to the public attention. There is an increasing concern of local and national psychotherapeutic associations concerning sexual contact between therapist and patient. Professional insurance carriers for psychiatrists and psychologists have been found quite unwilling to assume liability for malpractice suits involving sexual contact between therapists and patients (Asher, 1966).

The recent revisions of the ethics code for psychologists and psychiatrists specifically addressed these issues. The code of the American Psychological Association (1977) states,

"Sexual intimacies with clients are unethical"
(p. 23).

Similarly, the ethics principles for the American Psychiatric Association reads,

"Sexual activity with a patient is unethical"
(p. 1061).

Findings of the present study may aid in the understanding and clarification of specific attitudes held by the psychotherapists. An exploration of the attitudes can lead to an understanding of the actual practices of the psycho-
therapists. Moreover, a study of this nature can help psychotherapists gain a greater understanding of themselves. Clarification of a specific attitude when it is exemplified by a personal practice, can be either solidified, or expunged, when examined by the psychotherapist. Finally, the publication of the study will contribute to other psychotherapists not sampled in the study. The psychotherapists may use the research to examine and clarify their own attitudes and practices involving nonerotic and erotic contact with their patients.
Chapter II

REVIEW OF PERTINENT LITERATURE

Chapter II will be divided into three sections, Theoretical Issues, Ethical Guidelines, and Empirical Studies. As the present study is concerned with the attitudes of the psychotherapists toward nonerotic and erotic contact with their patients only the theoretical issue of sexual intimacy between patient and therapist, the moral considerations for the therapist, and the empirical studies dealing most directly with that topic area are reviewed here. Studies of the clients' attitudes, practices or reactions are not included in this study. Appendix A offers a bibliography regarding the clients and their reactions to the issue of intimacy between therapist and patient.

Theoretical Issues

The first concerns for the unexplored field of non-erotic and erotic contact between patient and therapist arose from three courses: (1) casual, personal observations, (2) statements of people in individual or group therapy, and (3) statements from colleagues. The most favorable and frequent reaction of therapists when hearing of patients' involvement with another therapist is that this surely must be fantasy, or it is proof of "positive transference" (Van Emde Boas, 1966, p. 215).
Van Emde Boas (1966) states further, that "there is a general denial regarding this concern, and the prevalent attitude is a protective professionalism" (p. 215).

In light of the protective professionalism intimacy between psychotherapist and patient has not been a subject of inquiry in the profession. Until recently, however, the attraction between psychotherapist and patient has been recognized since the earliest days of psychotherapy. Freud recognized the feelings of attraction between psychotherapist and patient but chose only to analyze the sexualized feelings of the patient for the therapist. Freud labeled the sexual feelings "transference". In tracing the sexual feelings to their presumed origins, they emerged as an important element in therapy.

When the feelings of transference were traced to their origins it was found that they arose out of "unresolved or conflicted sexual relationships with people in the past" (Holroyd, 1979, p. 13). Intimacy derived from the transference phenomenon is based on a confusion of emotions. These emotions may be misinterpreted by the patient and mistaken for sexual attraction for the therapist.

At best, it would be safer for the patient, and for the psychotherapist, to allow a degree of distance between the unresolved or sexual conflict from the past and the sexual attraction experienced in the present. Transference, "the psychoanalytic language applied to sex in psychotherapy has
effectively muted the impact of this emotion charged topic: transference and countertransference are intellectualized terms which provide distance from anxiety provoking sexual feelings they are intended to describe" (Holroyd, 1979, p. 5).

Winnicott (1965) has not written directly about intimacy between therapists and their patients, but alludes to the issue in some of his articles. Winnicott recognized the strain of the therapist in maintaining a professional attitude, suggesting that the therapist try to retain a human attitude, and yet behave ideally. Winnicott further states that there is a symbolism present within the professional attitude. It assumes that there is a distance between the therapist and the patient. The symbol is contained within the gap between the subjective object and the object that is perceived objectively (Winnicott, 1965).

Thus, psychoanalytic theory states that transference is the displacement of affect from the patient to the therapist. There is an assumption that psychotherapists who attributed sexual attraction in therapy to the patient's errant libido generally overlooked their own sexual motivations (Holroyd, 1979, p. 5). While research has begun to touch upon the sexual thoughts and feelings of the therapist there is a general reluctance to expose the therapist in great detail. There appears to be a fear that research might uncover the fact that, "....the psychoanalyst or psychotherapist is himself beset by deeply rooted, often unconscious needs that tend to foster
or stimulate impulses toward physical closeness towards the patient" (Marmor, 1972, p. 3).

Freud, in theory, views the displacement of affect from the patient to the psychoanalyst as strictly an emotional expression which should never be physically shown (Freud, 1924). Despite the awareness of the intensity of the transference phenomenon between therapist and patient the question of actual sexual intimacy with patients has been greatly ignored. Past studies have placed the displacement of affect from strictly the patient's perspective.

"We know that sexual relationships occur frequently, to the detriment of patients, and they probably did not begin yesterday (Holroyd, 1979, p. 4).

Only in the last few years has the exploration of the topic included the reactions and experiences of the therapist himself. It appears that any profession involving human beings is not immune to sexual temptation. An intensive psychotherapeutic transaction tends to foster a special quality of intimacy. When two people spend a considerable amount of time communicating about deeply intimate feelings, thoughts and experiences, they often grow fond of one another. The prolonged, intense, and intimate interpersonal nature of the relationship between therapist and patient may be viewed as both pleasurable and seductive on both sides. The nature of the relationship, coupled with the isolation involved in the therapeutic transaction that is bound to influence the communication between the psychotherapist and patient. "The intensity of feelings involved may shade over into a pleasurable
The possibility of erotic contact places responsibility on the role of the therapist. In light of the constrained role of the psychotherapist female patients often develop eroticized fantasies for their male therapist. Consequently, when the therapist lends reality to fantasies by suggestion or participation he fosters a serious confusion between what is actually reality and what is fantasy (Marmor, 1972). Similarly this confusion between states may overlap with adult behavior. Behaviors are frequently confused when the personal need for intimacy may be mistaken for an entirely different form of contact. For example, it would be relatively easy for two persons to indulge in sexual intercourse when it is the need for closeness or cuddling that is suppressed out of fear, anxiety, or shame (Forer, 1972). Research cannot infer that clients are manipulated or coerced into sexual activity but it seems apparent that patients are more open to the suggestions of their therapist than those that they would meet in everyday activity (Shepard, 1971).

Another explanation of transference comes from the writings of McCartney (1966). Transference arises out of a need, "...and is based on the possibility which a person offers to a lover for a fuller unfolding of his or her feelings by being in reality with that person" (p. 227). McCartney proscribes taking that material which lies in fantasy and placing it within reality by acting it out.
"The desire for emotional and physical acting out is as much a part of the newly discovered possibilities for relating as are the thoughts which belong to these possibilities" (McCartney, 1966, p. 229). Additionally, "...every psychiatrist has seen the need of some patients to show affection physically, and in forty years of analytic practice I have found that 10 to 30 percent requires some overt expression" (p. 228).

A rationalized explanation of sexual intimacy is described as "Overt transference". More clearly, this is defined as "....some visible, audible, or tangible muscular or glandular reaction to an inner feeling" (McCartney, 1966, p. 228). McCartney bases his writings on Meyers (1963). The psychosis that women may display has its origins in the female pelvis. The psychopathology of the female pelvis is essentially sexual. "The psychology of the woman depends on the functioning of her pelvis, which she uses as an organ of communication" (p. 678).

McCartney (1966) additionally adds that there is a need for the objectivity of the therapist in the acting out of the patients' fantasies. An essential component in the objectivity of the therapist is impartiality. "The therapist must at all times be appropriately responsible, but objective, and the patient may be overt in any way that is desired" (McCartney, 1966, p. 234). However, it is difficult to be in bed and be objective at the same time. When therapists are having sex with their patients, it is usually the therapists' needs that are getting met (Masters, 1969).

The needs of the therapist could probably be best narrowed to two:
1. Biological needs.

2. Psychological need to be a helping figure that is reinforced by actual needs and the dependency of the patient.

Dahlburg (1970) explains that the acting out of sexual fantasies is more common because of the increased need and the increased freedom to do so. "If other opportunities are limited, acting out may occur with patients" (p. 120). "It is probable that the best sexuality is always regressive to some degree, in the sense that more vivid and various sensations occur..." (p. 120)

Another regressive element is grandiosity. This can best be exemplified as the omniscient therapist who is going to cure his patient's frigidity through his own gentle teachings. "...the unspoken theme...is that the therapists attentions are what the patient really needs" (p. 120).

Marmor (1972) attempted to examine the hypothesis of whether or not unconscious feelings of superiority are present within the psychotherapist. He concluded that,

"...the constant exercise of authority carries with it the occupational hazard of tending to create unrealistic feelings of superiority in the authority figure" (p. 370).
"One of the primary contributions to feelings of superiority is the seductive influence of an abundant flow of transference admiration..." (p. 371).

Aside from the transference issue, the statement in reality is that the therapist is a very important person to the patient. The patient arrives at the therapist's door in
need. The psychotherapist in turn may address that need in any fashion that he chooses. Through the therapeutic transaction he can foster a greater dependence and need, or he may facilitate growth and awareness. Therapy is a joint venture. The primary supposition, by the very fact that the patient seeks the counsel of the psychotherapist, is that the therapist is better equipped to manage the therapeutic transaction. It is the management of the transaction that directs what the outcome of therapy will be.

"There is the fact that sexual acting out cannot be reversed. Once done, it remains a fact between the participants" (Dahlburg, 1970, p. 123). "The determinants of whether the therapist acts out are his inner states, rather than the seductiveness of the patient. The latter is always with us" (Dahlburg, 1970, p. 122).

Ethical Guidelines

The general reluctance to acknowledge the existence of sexual contact between psychotherapist and patient is a hindrance to this type of research. Results and conclusions of prior research state that it is the therapist that is the determinant figure in the relationship. According to Marmor (1972) it is how the therapist approaches emotional intimacy that decides the outcome of therapy. At best, an approach that could be exemplified by a clear distinction between what is nonerotic contact, and what is erotic contact.

The distinction between nonerotic and erotic contact may be quite spurious. What may be nonerotic contact to one
person, may be erotic contact to another. Some patients may sexualize all contact. Additionally, some therapists may be unaware of their own sexual arousal during nonerotic encounters during the transference. This then communicates to the patient a completely different message. The definition of what may be nonerotic or erotic depends so much upon the situation, the context, or the circumstances (Holroyd, 1979, p. 8).

The situation is the fact that the patient approached the therapist. The context would be the therapeutic transaction between psychotherapist and patient. The circumstance is the proposition that all human beings share the universal need to be loved. Kardener (1974) reaffirms that patients retain this need to be loved. The first place a patient will attempt to fulfill the need to be loved would be within the therapeutic transaction. A positive outcome of therapy would assume that the patient's emotional needs of love and acceptance were met. Additionally, the therapist retains this need to be loved. When the need states of love and acceptance are acted out in a sexual fantasy, it is difficult to discern whose needs are actually being met: the client's, or the psychotherapist's? The choice of whether a sexual fantasy is acted upon in the therapeutic hour is usually chosen from the perspective of the therapist.

The essential foundation for a therapeutic relationship is basic trust. A patient is encouraged to set aside all defenses and open up completely to the psychotherapist. In fact,
in order for therapy to progress, the laying aside of defenses is essential to therapeutic growth. The patient is then placed in a weakened, vulnerable condition. This is a condition that is exemplified in the state of being a child.

Because of the sociobiological condition of the human child, dependence on a parental figure is essential for survival. Probably for that reason every culture has designed taboos in the choice of sexual partners (e.g., to guarantee the availability of a parenting person to the developing child). The physician (psychotherapist) is seen as a caretaker. In a parallel way the psychotherapist, as a source of healing, support and succor, becomes lost to this patient when he changes roles and becomes a lover (Kardener, 1974). Patients entrust themselves to the psychotherapist. They place themselves in the hands of the therapist "and allow him to infringe upon all areas of their life customarily kept hidden" (Barceland, 1969, p. 121). Caplan (1964) clarifies this supposition even further, "The patient is prepared to undress and permit physical examination, allow collection of his body fluids and talk about thoughts, feelings, and actions normally kept secret. This leads to a dependent relationship with the therapist, whose power over him is checked by a complicated system of controls associated with professional ethics and governmental surveillance of his profession. When a patient goes to a therapist, he relies on these controls to guard his interests" (p. 242).

Ethics, Webster (1968) states, "....is a theory or system of moral values: the principles of conduct governing an individual or a group; it is the discipline dealing with
what is good and bad and with moral duty and obligation" (p. 285). Many therapists may regulate their behavior by applying a moral or ethical standard. We live in an age in which people appreciate relative values and are no longer content with absolutes. Moral rules and regulations are subjectively tailored to the situation and the context within which they initiate. Due to the vagueness of modern ethical standards governing bodies created rules and regulations to control therapists' conduct: The American Psychological Association (1977) states,

"Sexual intimacies with clients are unethical" (p. 23).

Additionally, the American Psychiatric Association (1973) adds,

"Sexual activity with a patient is unethical" (p. 1061).

Other sources of ethical considerations are cultural. Sexual acting out in therapy may be related in frequent touch in therapy. The leading theorists of psychotherapy have been from Teutonic, English, and American origins, societies which share a taboo against touching. The taboo is the belief that touching is either directly sexual, or is an invitation to sex, "...and must therefore be avoided in a therapeutic relationship" (Older, 1977, p. 198). The strength of the sex taboo may be imposing too great a restraint on touch in therapy. Touch is one of the first senses to develop. It is the earliest and one of the most basic forms of human interaction. By not touching patients, therapists cut themselves off from a very basic way
of making contact and providing comfort. Touching may be used to say quite simply, "I do care". The distinguishing line is between touch to make contact, because psychotherapists do care about their patients, and touching to make sexual contact.

Ethical guidelines govern psychotherapists against sex in therapy with a number of factors. The choice of whether the therapist acts out sexually is governed by his/her subjective view regarding ethics and morals. As stated, the therapeutic relationship is not a relationship of equals. There is a carryover of the incest taboo. The dependency implied within the transaction exemplifies this aspect. If a therapist is involved in a sexual relationship with a client he/she is receiving some benefits. Therefore, exploitation of the patient becomes a real possibility. In sum, as Older (1977) states,

"Therapy - not sex - is the business of the therapist" (p. 198).

**Empirical Studies**

Butler and Zelen in 1977 studies twenty volunteer psychiatrists and psychologists who had engaged in sexual contact with their patients. In the majority of cases, intimacy was found to have developed through the initiation of the therapist. The therapist would first approach the issue of his sexual attraction for the patient. The outcome would then have one of three results: (1) there was an acceptance of a mutual attraction, and somehow vaguely the therapist would lose control of the therapeutic hour. The relationship
changed from a therapeutically oriented one to a more egalitarian relationship; (2) the therapist's innuendoes would lead to further discussion and eventually to intercourse; or (3) the therapist's innuendoes were almost immediately acted out. There was only one case where the proposition was immediately rejected. (The woman in that case immediately terminated therapy.) However, in no case was there any type of formal complaint of misconduct made.

Ninety percent of the therapists reported having been vulnerable, needy and/or lonely when the sexual contact occurred. The high need states were said to have been correlated with unsatisfying marriages, separations, and divorces (Butler & Zelen, 1977).

The California State Psychological Association Task Force on Sexual Intimacy with Clients, relying on the information provided by therapists of patients who had sex with previous therapists, also found that the therapist was usually the one to initiate sexual activity. The study also indicated that the sexual contact most often occurred in the therapist's office, and interestingly, that therapy payments continued after the sex began in most cases (Holroyd, 1979, p. 18).

Additionally, there were attempts to conduct surveys regarding attitudes and practices involving nonerotic and erotic contact between physician and patient. The three most significant to date are Kardener, Fuller, and Mensch in 1973,

Kardener, Fuller and Mensh (1973) conducted an investigation of male physicians' attitudes and practices regarding erotic and nonerotic contact with their patients. The investigation was based upon an anonymous questionnaire survey of a random sampling of one thousand physicians from the membership list of a local county medical society in Los Angeles. The study sample represented the five specialty groups: psychiatry, obstetrics-gynecology, surgery, internal medicine, and general practice. They found that out of the forty-six (46%) percent that responded there were differing views regarding the nonerotic and erotic contact. In general, seventy-one percent of the responding physicians did not believe in the efficacy of or engage in nonerotic contact with their patients. At the same time, seventy-four percent recognized the value of nonerotic contact in providing comfort or support to the patient. Finally, sixty-nine percent believed that non-erotic contact would be misunderstood.

The views of the physicians regarding erotic contact were similarly conservative. The majority of the physicians, eighty-seven percent, stated that erotic contact was never of benefit, and eighty-nine percent reported having had no participation in erotic contact. Eleven percent reported having participated in erotic contact; and seventy percent of this sample stated that it occurred in fewer than five patients. All of the other eleven percent reported contact including
intercourse, and seventy-nine percent of the latter group reported an incident rate of fewer than five patients. The physicians that saw the usefulness of erotic contact totaled thirteen percent. The specialty groups that conveyed this positive perspective of erotic contact consisted of: 1 general practitioner, 5 internists, 6 OB-GYN's, 6 surgeons, and 10 psychiatrists.

Overall, psychiatrists and OB-GYN's reported a higher frequency of treatment of sexual problems. Of all the specialties, OB-GYN's were the most wary of nonerotic contact with their patients. The physicians stated that it could be most easily misunderstood. Yet, the psychiatrists most often said that nonerotic contact could be beneficial. Internists and GP's indicated a firm belief in, and the practice of beneficial nonerotic contact. The specialties most favorable toward erotic contact were psychiatrists and surgeons.

The prior surveys of male physicians' attitudes regarding erotic and nonerotic contact led Perry, (1976) to compile a sampling of female physicians' attitudes. Perry's questionnaire was mailed to a systematic random sampling of five hundred female physicians, half in New York and half in California. Responses were again anonymous. Thirty-three percent of the five hundred physicians responded. Seventeen specialty groups were represented among the female physicians. Generally, it was discovered that women physicians under thirty believed and engaged in nonerotic contact with their patients more often
than female physicians over thirty. Thirty-nine percent believed in the efficacy of nonerotic contact when it was used to reassure or empathize with a patient. Twenty percent considered nonerotic contact appropriate during a crisis. An additional twenty percent declared the contact appropriate for the young or with elderly patients. And six percent stated that it was necessary for schizophrenic or depressed patients. Eight percent stated that nonerotic contact would not be beneficial or appropriate at all. Although two percent of the sample reported that erotic contact would be beneficial, ninety-eight percent stated that erotic contact should never include intercourse. Only one female physician reported erotic contact, without intercourse, and no female physician reported any coital involvement. The majority of the physicians, seventy-seven percent, declared that erotic contact is never beneficial and twenty-three percent said that it would be appropriate for "instruction" or "specific sexual problems".

In summary, 87% of the male physicians, consistently opposed erotic contact, and yet 11% stated that they had engaged in erotic contact. While 77% of the female physicians opposed erotic contact, and 23% said that erotic contact would be appropriate for specific circumstances, only one had reported erotic contact. The significant variance in opinion which appears in the two above mentioned studies is based on gender differences. The majority of male physicians do not believe in erotic involvement with their patients. In practice, how-
ever, there are instances of actual involvement. Female phy-
sicians consistently oppose erotic involvement and report no
incidences of coital involvement.

The third study of psychotherapists' attitudes and
practices regarding erotic and nonerotic physical contact with
patients was conducted by Holroyd and Brodsky (1977). They
conducted a nationwide survey of one thousand psychologists
(500 men and 500 women). The sample was selected from 27,000
respondents of the 1974 APA Manpower survey. There was a seventy
percent response rate (703).

Seventy-six percent of the therapists treated sexual
problems in their practice at least occasionally. Approximately
half of the therapists thought that nonerotic contact would be
beneficial at least occasionally in a therapeutic practice.
This was designated to be helpful for:

1. Socially or emotionally immature clients
   schizophrenics, or patients with a history of
   maternal deprivation).

2. For periods of acute distress such as grief,
   trauma or severe depression.

3. General emotional support (including warmth,
   reinforcement, contact, and reassurance).

4. For greeting or termination.

With regard to erotic contact, only four percent of the
respondents thought that erotic contact would be beneficial in
treatment. Seventy percent of the males and eighty-eight percent
of the females thought that erotic contact would never benefit patients. Nine percent of the respondents suggested the use of a sex surrogate for the treatment of sexual problems. Only in that instance would erotic behavior be utilized in treatment.

"Interestingly, respondents thought that the patient for whom erotic contact might be utilized in treatment should be either very integrated (e.g., "an extremely stable person whose only difficulty is sexual problems") or, a severely regressed psychotic patient (Holroyd & Brodsky, 1977, p. 845).

Twenty-seven percent of the therapists occasionally engaged in nonerotic contact with their patients. In comparison, 93% of therapists who participated in past erotic contact with patients reported that they were not currently engaged in erotic contact with their patients.

Four percent of the therapists rarely participated in erotic contact, and zero percent reported occasional or frequent current contact. Past erotic contact, excluding intercourse, involved 10.9% of male psychologists and 1.9% of the female psychologists. To the question of erotic contact, including sexual intercourse, 5.5% of the men and .6% of the women responded affirmatively. 7.2% of the men, and .6% of the women indicated that they had engaged in intercourse within three months after the termination of treatment.

There is a similarity between the responses of the Kardener et al. (1973) study of male physicians and the male responses of the Holroyd study. Again, evidence also demonstrates that a significantly higher proportion of males than females believe that erotic contact with patients might be
beneficial to their treatment. For all the questions concerned with erotic contact and intercourse, more males than females answered positively.

**Summary of the Pertinent Literature**

The purpose of the chapter was to review the provisions for which interaction between patient and psychotherapist was based. These provisions included a review of the theoretical constructs and an exploration of the ethical guidelines for defining and establishing nonerotic and erotic contact. Also included in this chapter was a review of the empirical studies of the attitudes and practices of psychotherapists.

In the discussion of the theoretical constructs it was found that transference is the basis upon which any sexual acting out between psychotherapist and patient were based. The intimate nature and isolation of the psychotherapeutic trans-action presents a great many factors which influence and direct the transference and countertransference. Among these are: The strain of maintaining the role of the psychotherapist; the assumption that sexual attraction is only illicited from the patient; and the interpersonal nature of the relationship. It was also discovered that any sexual intimacy between therapist and patient was influenced directly by the psychological state of the therapist. Psychological factors that were found to be of importance were: The emotional need to be a helping figure, that is reinforced by the dependency needs of the
patient; the burden of isolation; and feelings of grandiosity and superiority.

It was also discovered that there is a necessity for ethical guidelines for the psychotherapists. Within the therapeutic transaction it was found that there is a possibility for exploitation of the patient. Hence, the therapist must follow these ethical guidelines because the therapeutic relationship begins in an unequal and dependent stance.

Empirical studies indicate that erotic contact between therapist and patient does exist. In the majority of cases the contact evolves from the psychotherapist's own biological or emotionally needy state. It is further indicated that intimate contact derived from these sources is most often sexually acted out.
Chapter III  
DESIGN AND PROCEDURES

Statement of the Problem

The primary purpose of this study is to determine what the attitudes of psychiatrists and psychologists are regarding nonerotic and erotic contact with their patients. A dual aim will be to determine what are the actual practices of the psychiatrists and psychologists with regard to nonerotic and erotic contact.

The study will also seek to determine if the attitudes of the psychiatrists and psychologists are significantly related to the actual practices of the psychotherapists. By means of a questionnaire, data was gathered regarding the rationale used by the psychotherapists in determining their attitudes and practices regarding nonerotic and erotic contact with their patients. The questionnaire also sought to determine if the psychotherapists believed that nonerotic and erotic contact was beneficial to a patient in treatment.

Definition of Terms

The following definitions have been used in the conduct of this investigation.

Nonerotic Contact. Nonerotic contact is defined as behavior, such as hugging, kissing, and touching, when the intention of such acts is nonsexual in nature.
Erotic Contact. Erotic contact is any contact that is primarily intended to arouse or satisfy sexual desire.

Psychotherapist. In this study psychotherapist will be used to refer to the respondents of the study. The psychotherapist is either a

(1) psychologist, with a practicing clinical license, or

(2) medical doctor licensed by the board of examiners in the State of California, specializing in the area of psychiatry.

Population and Sample

The population of interest is a group of doctorally trained persons who are practicing psychotherapists. For sampling purposes, the psychiatrists and psychologists in Palo Alto, California, were chosen for a number of reasons:

The first study in the field was completed by Kardener, Fuller and Mensh in 1973. They gathered results from the population offered by a Los Angeles medical society. Kardener et al. (1973) focused exclusively on male physicians. Perry in 1976 studied the results of a sample taken from New York and California. Perry's study consisted of respondents who were practicing female physicians. The last survey in 1977, was conducted by Holroyd and Brodsky. Holroyd and Brodsky (1977) gathered a random sampling of psychologists,
who had attended an American Psychological Association's Manpower Conference, taken from a nationwide population.

It seems apparent that none of the studies attempted to gather data from a localized demographic area small in design. Second, the attitudes of a population offered by a university town is an area of interest to the researcher. Third, the researcher lives and works in Palo Alto, and was interested in discovering the types of attitudes held by the surrounding populus. And fourth, the topic of sexual intimacy with clients is an area of concern to the researcher, as a practicing therapist.

The population of interest was taken from the psychiatrists and psychologists listed in the yellow pages of the telephone directory. The therapists were limited to those therapists listing both addresses and telephone numbers in the directory. The population consisted of one hundred and thirty-five psychotherapists. The breakdown is as follows: 15 women psychiatrists, 61 male psychiatrists, 22 female psychologists, and 37 male psychologists.
**Instruments**

The cover letter and questionnaire utilized by Kardener et al. (1973) were employed as a basis for reference. A new cover letter was devised along with the development of a twenty-one item, one page questionnaire. A sample of the cover letter may be found in Appendix B.

In the self-administration to the questionnaire, the subject is directed to respond to thirteen of the twenty-one items with a Likert-type continuum from 1 - 5. One is assigned to the response of "never". Two indicates that the response occurs less than 5% of the time (rarely). Three indicates that the response occurs in less than 25% of the time (occasionally). Four indicates "frequently", the response that occurs in 26% - 50% of the time. Five states that the response occurs "nearly always".

Four of the items on the questionnaire are open ended, and call for personal opinions. The subjects were asked to place their write-in responses on the back of the questionnaire. Five of the items call for fill-in responses, which range from checks in the appropriate places to a brief write-in.
SURVEY QUESTIONNAIRE: EROTIC AND NONEROTIC CONTACT
BETWEEN PATIENT AND PSYCHOTHERAPIST

1. General Information:
   a) Your age:   b) Your sex:   c) Marital Status:   d) Years in Practice:
      Under 30____   M______   Married____   1 - 10____
      30 - 50____   F______   Single, Widowed____   11 - 25____
      Divorced____   over 25____

(Definition: Nonerotic contact can be defined as behaviors, such as hugging, kissing and touching, when the intention is nonsexual in nature.

Erotic contact is any contact that is primarily intended to arouse or satisfy sexual desire.)

(Scale: (1) NEVER (2) RARELY (less than 5%) (3) OCCASIONALLY (less than 25%) (4) FREQUENTLY (26% to 50%) (5) NEARLY ALWAYS)

Please place your write-in responses on the back and rate the following by circling the appropriate number.

2. Do you treat sexual problems in your practice? 1 2 3 4 5
3. Do you treat a significant number of men for sexual problems in your practice? 1 2 3 4 5
4. Do you treat a significant number of women for sexual problems in your practice? 1 2 3 4 5
5. Do you believe nonerotic contact is beneficial in a psychotherapy practice? 1 2 3 4 5
6. Do you utilize nonerotic contact in your practice? 1 2 3 4 5
7. Do you believe that nonerotic contact might be misunderstood? 1 2 3 4 5
8. Who is usually the initiator of the nonerotic contact?  a) yourself  b) patient 1 2 3 4 5
9. Under what conditions might nonerotic contact be beneficial? 1 2 3 4 5
10. Do you believe erotic contact is beneficial in a psychotherapy practice? 1 2 3 4 5
11. Do you utilize erotic contact in your practice? 1 2 3 4 5
12. Do you believe that erotic contact might be misunderstood? 1 2 3 4 5
13. Who is usually the initiator of the erotic contact?  a) yourself  b) patient 1 2 3 4 5
14. In the past three years, with how many patients, have you had sexual intercourse? _____
15. Under what conditions might erotic contact be beneficial? 1 2 3 4 5
16. If you have engaged in erotic contact, what were the reasons for participating in the erotic contact? 1 2 3 4 5
17. If this did occur, what was the impact on the treatment? 1 2 3 4 5
18. Other comments?
Organization of the Questionnaire

The questionnaire, which may be found within the text, is divided into five sections: The first section, designated under the subheading of General Information, consists of four items used to measure variables thought by this researcher to influence the type of attitudinal data collected.

Dividing the preceding area with the items that are scored by the Likert-type scale or the write-in responses, is an area defining the terms used in the questionnaire and the definitions of the scaled responses. The second section of the questionnaire collected data regarding the treatment of sexual problems in the psychotherapy practice. The third and fourth section assessed the nature of nonerotic and erotic contact, from the perspective of the therapist. More specifically, how beneficial the therapist thought the contact was; whether they utilized the contact; and if contact with patients might be misunderstood.
Methodology

It was considered desirable to keep the administrative procedures to a minimum for the convenience of the psychiatrists and psychologists participating in the study. Also due to the controversy of the topic matter, anonymity was guaranteed. To encourage a greater response rate all personal contact between researcher and subject was obliterated. Therefore, the questionnaires were designed to be self-administering. Participation in the study, while encouraged, was represented to prospective subjects as completely voluntary.

A copy of the questionnaire was mailed to the prospective subjects along with a stamped addressed envelope, and an appropriate cover letter. A stamped post card was also included for those subjects requesting a summary of results. The cover letter consisted of a statement of the research problem; a statement of research intent and purpose; an explanation of the population being studied; an invitation to participate on an anonymous basis within the study; the request for the questionnaire completion date; and a university statement of endorsement. Due to the sensitivity of the data collected, the letter was written on university stationery to add validation and reliability to the research subject. To further erase personal contact between researcher and subject, the envelopes were stamped with the university stamp and responses were sent directly to the university. A copy of this letter is included in Appendix B.
Hypotheses and Data Analysis

Research Hypotheses: Based upon review of the literature the following hypotheses regarding the attitudes and practices of nonerotic and erotic contact between patient and psychotherapists are presented. Thirty-four hypotheses were utilized to investigate the relationship of interest. Hypothesis 1 and 2 were examined by a Pearson correlation. The remaining 32 were tested by a one way analysis of variance. A significance level of .05 was established for testing purposes.

Hypotheses

Hypothesis 1
The attitudes of the psychotherapists regarding nonerotic contact are significantly related to the actual practices of nonerotic contact of the psychotherapists.

Hypothesis 2
The attitudes of the psychotherapists regarding erotic contact are significantly related to the actual practices of erotic contact of the psychotherapists.

A supplemental analysis of data was designed to reveal summary statistics for the total group of psychotherapists studied. The summary statistics for the group of psycho-
therapists were derived by determining the proportionate number of psychotherapists selecting each response option.

Hypotheses 3 - 34 are based upon the variables of sex, age, marital status, and years in practice. In each subgroup the hypotheses were established for each of items 5, 6, 7, 8, 10, 11, 12, and 13. The hypotheses take the general form as follows.

Hypothesis subgroup 1
The male psychotherapists' responses will differ significantly from the female psychotherapists' responses.

Hypothesis subgroup 2
The married psychotherapists' responses will differ significantly from the nonmarried psychotherapists' responses.

Hypothesis subgroup 3
The psychotherapists' responses will differ significantly according to years in practice.

Hypothesis subgroup 4
The psychotherapists' responses will differ significantly according to age.
The methods of statistical analysis used to test the hypotheses, were determined by response format, scoring scales, and the number of respondents addressing the various subsections. For testing purposes, the hypotheses were stated as null hypotheses and will be so reported in Chapter IV.
Chapter IV
RESULTS OF THE STUDY

This chapter presents the results obtained from the analysis of the data. Discussion and interpretation of findings will accompany each set of data as it is presented. This chapter will consist of three parts: (1) The Statistics for the total group and the various subgroups; (2) the testing of the hypotheses; and (3) a discussion of results.

The population sampled totaled 135. Out of the 135 sampled, 67 responded with a completed questionnaire. Five of the questionnaires were returned via the mail, marked "no such person, no such address". Two questionnaires were returned completed, after the deadline. And one questionnaire was returned by the therapist's secretary stating that the therapist was on vacation.

The results obtained from the data analysis will be summarized in the following manner: The summary statistics for the total group will be stated. Second, the statistics for the subgroups will the be presented. Third, the data obtained from the total group and the subgroups will be analyzed in the testing of the hypotheses. These hypotheses will be presented in the research form, but were tested in the null form. And finally, the results will be discussed in a separate section in terms of the relationships between the variables and the hypotheses.
Statistics for the Total Group

The responses of the total group are displayed in Table 1. Table 2 presents the same results in terms of the percentages within the total group.

These tables are provided for the reader to facilitate the understanding of the response percentages to the questionnaire.

Statistics for the Subgroups

The subgroup statistics are presented in the form of mean scores. The data of interest came from questions 5 - 8, and questions 10 - 13. These statistics can be found in the following tables: The mean scores for the questions with regard to gender differences, may be found in Table 5. Years in practice mean scores are provided in Table 6. Table 7 consists of the mean scores for the questions with regard to age differences. And the mean scores for marital status are listed in Table 8.
SURVEY QUESTIONNAIRE: EROTIC AND NONEROTIC CONTACT BETWEEN PATIENT AND PSYCHOTHERAPIST

1. General Information:
   a) Your age:  
   Under 30  
   30 - 50  
   50 - 70  
   70 -
   b) Your sex:  
   M  
   F  
   c) Marital Status:  
   Married  
   Single, Widowed  
   Divorced  
   d) Years in Practice:  
   1 - 10  
   11 - 25  
   Over 25  

(Definition: Nonerotic contact can be defined as behaviors, such as hugging, kissing and touching, when the intention is nonsexual in nature. Erotic contact is any contact that is primarily intended to arouse or satisfy sexual desire.)

(Scale: (1) NEVER (2) RARELY (less than 5%) (3) OCCASIONALLY (less than 25%) (4) FREQUENTLY (26% to 50%) (5) NEARLY ALWAYS) Please place your write-in responses on the back and rate the following by circling the appropriate number.

2. Do you treat sexual problems in your practice?  
   1 2 3 4 5

3. Do you treat a significant number of men for sexual problems in your practice?  
   1 2 3 4 5

4. Do you treat a significant number of women for sexual problems in your practice?  
   1 2 3 4 5

5. Do you believe nonerotic contact is beneficial in a psychotherapy practice?  
   1 2 3 4 5

6. Do you utilize nonerotic contact in your practice?  
   1 2 3 4 5

7. Do you believe that nonerotic contact might be misunderstood?  
   1 2 3 4 5

8. Who is usually the initiator of the nonerotic contact?  
   a) yourself  
   b) patient  
   1 2 3 4 5

9. Under what conditions might nonerotic contact be beneficial?  
   1 2 3 4 5

10. Do you believe erotic contact is beneficial in a psychotherapy practice?  
    1 2 3 4 5

11. Do you utilize erotic contact in your practice?  
    1 2 3 4 5

12. Do you believe that erotic contact might be misunderstood?  
    1 2 3 4 5

13. Who is usually the initiator of the erotic contact?  
    a) yourself  
    b) patient  
    1 2 3 4 5

14. In the past three years, with how many patients, have you had sexual intercourse?  
    _____

15. Under what conditions might erotic contact be beneficial?  
   1 2 3 4 5

16. If you have engaged in erotic contact, what were the reasons for participating in the erotic contact?  

17. If this did occur, what was the impact on the treatment?  

18. Other comments?
Table 1

Frequency of Response to each Questionnaire Item

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Key: 1 = Never; 2 = Rarely (less than 5%); 3 = Occasionally (less than 25%); 4 = Frequently (26% to 50%); 5 = Nearly Always
Table 2  
Percentage of Responses  
To each Questionnaire Item  

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Key: 1=Never; 2=Rarely (Less than 5%); 3=Occasionally (Less than 25%); 4=Frequently (26% to 50%); 5=Nearly Always.
Testing of the Hypotheses

Research Hypothesis 1

The attitudes of the psychotherapists regarding nonerotic contact are significantly related to the actual practices of the nonerotic contact of the psychotherapists.

Hypothesis 1 was tested in the null form by determining if a relationship existed between questions 5 and 6. The breakdown of data on these variables is provided in Table 3. The questions are as follows:

5. Do you believe nonerotic contact is beneficial in a psychotherapy practice?
6. Do you utilize nonerotic contact in your practice?

In testing Hypothesis 1, a correlation coefficient was computed on the data of the preceding two questions. The degree of correlation demonstrated was .70, which was significant far beyond the .01 level. This demonstrates a relationship between the two questions, therefore, the null hypothesis is rejected. Thus, it can be said the attitudes of the psychotherapists regarding nonerotic contact was significantly related to the reported practices of nonerotic contact of the psychotherapists.
Almost half of the psychotherapists (45.5%) responded that nonerotic contact was beneficial in a therapy practice less than 5% (rarely) of the time. The psychotherapists that responded that nonerotic contact was never of benefit totaled 19.5% (13). The third largest percentage of the therapists, 18.2% (12), stated that it was beneficial occasionally (less than 25% of the time). Only 4.5% (2) of the therapists said that nonerotic contact was nearly always of benefit. The mean score for question 5 was 2.338. Therefore, the results indicate that a large majority of the respondents finds nonerotic contact of benefit less than 5% of the time.

In response to question 6, psychotherapists totaling 40.6% of the sample stated that they utilized nonerotic contact rarely. Twenty-five percent (17) of the therapists never utilized nonerotic contact, while 22.7% (15) responded that they used the contact occasionally. Two (3.0%) therapists nearly always utilized nonerotic contact. The mean score for the utilization of nonerotic contact was 2.212, indicating that for the group at large, the contact is used less than 5% of the time.

In summary, a substantial proportion of psychotherapists (45.5%) find nonerotic contact of benefit less than 5% of the time. And further, forty percent of the therapists utilize nonerotic contact less than 5% of the time. Therefore, research Hypothesis 1 is retained.
Research Hypothesis 2

The attitudes of the psychotherapists regarding erotic contact are significantly related to the actual practices of erotic contact of the psychotherapists.

Hypothesis 2 was tested in null form by determining if a significant relationship existed between questions 10 and 11. The breakdown of variables for these questions are found in Table 4. The questions are as follows:

10. Do you believe erotic contact is beneficial in a psychotherapy practice?
11. Do you utilize erotic contact in your practice?

In testing Hypothesis 2, a correlation coefficient was computed on the preceding two variables. The degree of correlation demonstrated was .75, which was significant far beyond the .01 level. This demonstrates a relationship between the two questions, therefore, the null hypothesis is rejected. Accordingly, research Hypothesis 2 is accepted. The attitudes of the psychotherapists regarding erotic contact were significantly related to the reported practices of erotic contact of the psychotherapists.

The data revealed that 86.4% (57) of the psychotherapists responded that erotic contact was never of benefit in a therapy practice. The therapists that responded that ero-
tic contact was rarely of benefit totaled 9.1% (1). One (3.0%) therapist stated that erotic contact was beneficial occasionally, but less than 5% of the time. The mean score for question 10 was 1.125.

In response to question 11, 93.9% (62) of the therapists stated that they never utilized erotic contact in their practice. One psychotherapist rarely utilized erotic contact, and another utilized the contact occasionally. The mean score for question 11 was 1.166. In addition to questions 10 and 11, question 14, asks for the number of patients, in the past three years, with whom the therapist has had sexual intercourse. On this question, only one therapist reported sexual intercourse, with one patient. Therefore, results reveal that almost the entire population of psychotherapists never utilize erotic contact in their practice.

The relationship can be summarized in the following manner: Almost all of the therapists in the population never find erotic contact of benefit (86.4%). And finally, that almost all of the therapists (93.9%) responded that they never utilized erotic contact, and only one reported sexual intercourse with one patient.
Table 3
Attitudes and Practices of Psychotherapists regarding Nonerotic Contact

Question 5: Do you believe nonerotic contact is beneficial in a psychotherapy practice?

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean Scores</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30 (Only one individual)</td>
<td>4.00</td>
<td>.0</td>
</tr>
<tr>
<td>30 - 50</td>
<td>2.32</td>
<td>1.06</td>
</tr>
<tr>
<td>50 and over</td>
<td>2.13</td>
<td>1.08</td>
</tr>
<tr>
<td>married</td>
<td>2.20</td>
<td>1.13</td>
</tr>
<tr>
<td>not married</td>
<td>2.36</td>
<td>1.06</td>
</tr>
<tr>
<td>1 - 10 years in practice</td>
<td>2.36</td>
<td>.92</td>
</tr>
<tr>
<td>11 - 25 years in practice</td>
<td>2.40</td>
<td>1.21</td>
</tr>
<tr>
<td>25 and more years in practice</td>
<td>2.00</td>
<td>1.06</td>
</tr>
<tr>
<td>Males</td>
<td>2.22</td>
<td>1.01</td>
</tr>
<tr>
<td>Females</td>
<td>2.63</td>
<td>1.20</td>
</tr>
</tbody>
</table>

Question 6: Do you utilize nonerotic contact in your practice?

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean Scores</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 - 50</td>
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</tr>
<tr>
<td>50 and over</td>
<td>2.10</td>
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</tr>
<tr>
<td>married</td>
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<td>.96</td>
</tr>
<tr>
<td>not married</td>
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<td>1.27</td>
</tr>
<tr>
<td>1 - 10 years in practice</td>
<td>2.16</td>
<td>.83</td>
</tr>
<tr>
<td>11 - 25 years in practice</td>
<td>2.32</td>
<td>1.21</td>
</tr>
<tr>
<td>25 and more years in practice</td>
<td>2.00</td>
<td>.92</td>
</tr>
<tr>
<td>Males</td>
<td>2.22</td>
<td>.97</td>
</tr>
<tr>
<td>Females</td>
<td>2.47</td>
<td>1.12</td>
</tr>
</tbody>
</table>
Table 4
Attitudes and Practises of Psychotherapists regarding Erotic Contact

Question 10: Do you believe erotic contact is beneficial in a psychotherapy practice?

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean Scores</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30 (Only one individual)</td>
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<td>.0</td>
</tr>
<tr>
<td>30 - 50</td>
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<td>.31</td>
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<td>50 and over</td>
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<td>.61</td>
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<tr>
<td>married</td>
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<td>.40</td>
</tr>
<tr>
<td>not married</td>
<td>1.00</td>
<td>.0</td>
</tr>
<tr>
<td>1 - 10 years in practice</td>
<td>1.06</td>
<td>.25</td>
</tr>
<tr>
<td>11 - 25 years in practice</td>
<td>1.14</td>
<td>.36</td>
</tr>
<tr>
<td>25 and more years in practice</td>
<td>1.25</td>
<td>.70</td>
</tr>
<tr>
<td>Males</td>
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<td>.41</td>
</tr>
<tr>
<td>Females</td>
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<td>.24</td>
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</table>

Question 11: Do you utilize erotic contact in your practice?

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean Scores</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>under 30 (only one individual)</td>
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<td>.0</td>
</tr>
<tr>
<td>30 - 50</td>
<td>1.10</td>
<td>.57</td>
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<tr>
<td>50 and over</td>
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<tr>
<td>married</td>
<td>1.36</td>
<td>0.61</td>
</tr>
<tr>
<td>not married</td>
<td>1.12</td>
<td>1.20</td>
</tr>
<tr>
<td>1 - 10 years in practice</td>
<td>1.00</td>
<td>.0</td>
</tr>
<tr>
<td>11 - 25 years in practice</td>
<td>1.32</td>
<td>1.05</td>
</tr>
<tr>
<td>25 and more years in practice</td>
<td>1.25</td>
<td>.70</td>
</tr>
<tr>
<td>Males</td>
<td>1.14</td>
<td>.64</td>
</tr>
<tr>
<td>Females</td>
<td>1.23</td>
<td>.97</td>
</tr>
</tbody>
</table>
Research Hypotheses 3 - 34

As stated in Chapter III, the hypotheses for questions 5, 6, 7, 8, 10, 11, 12, and 13, and the variables of gender, years in practice, age, and marital status, were analyzed statistically with a one way analysis of variance in the null form. Additionally, as stated in Chapter III, the 0.5 level of significance was established.

The hypotheses will first be presented as originally stated, in the research form. The statistics will then be given and discussed for the hypotheses in the null form. In conclusion, the action taken on the null hypotheses will then be stated in a substantive manner. The hypotheses will be presented in this fashion to ease confusion, and to insure greater continuity for the reader.

The between groups degrees of freedom in the testing of these hypotheses were always one or two, depending upon whether there were two or three groups. These degrees of freedom will be indicated in the set of each results. The within groups degrees of freedom will always be either 62 or 63, depending again on the number of groups tested. And unless the obtained F values approach those that accompany the table values for these degrees of freedom, the within degrees of freedom will not be mentioned in the text.
Research Hypotheses 3 - 10

The male psychotherapists' responses will differ significantly from the female psychotherapists' responses, on the above indicated eight variables.

The means and standard deviations for Hypotheses 3 - 10 may be found in Table 5. There were only slight group differences in all of the questions except question 13.a., where there was no difference at all between the two groups! Results of testing Hypotheses 3 - 10 show that men and women do not differ in their responses regarding nonerotic and erotic contact with patients. Thus, for each of Hypotheses 3 - 10, the null hypotheses were retained, since no F-ratios exceeding the critical F-ratio of 4.00 with one between degrees of freedom was observed.
Question 5: There were little differences between the men and women with regard to the expected benefits of nonerotic contact. The mean score for men was 2.22, and for women, 2.62. The standard deviations were 1.01 and 1.20 respectively. The f-ratio, 1.55, was non-significant, at the established .05 level for rejection. Thus, null hypothesis 3 was retained.

Question 6: There were no differences between the men and women with regard to the utilization of nonerotic contact. The mean score for men was 2.12, and the standard deviation was .97. The mean score for women was 2.47, and the standard deviation was 1.12. The f-ratio at 1.49, proved to be non-significant at the .05 level for rejection. Null Hypothesis 4 was accepted.

Question 7: This question deals with whether men and women differ in attitude about nonerotic contact being misunderstood. The difference in means was not significant. The mean score for women was 3.29, with a standard deviation of .98. The f-ratio of .28 was not significant at the .05 level. Therefore, null Hypothesis .5 is upheld.

Question 8.a.: Men and women did not differ in their attitudes regarding the initiation of nonerotic contact. The mean score for men was 2.28, and for women was 2.83. The standard deviations were 1.13 and 1.26 respectively. The f-ratio was 2.07.
Question 8.b. produced mean scores for men of 2.83, and for women of 3.16. The standard deviation for men was 1.27, and for women, 1.26. The f-ratio of .63, indicates that there was no significant difference between males and females in the initiation of nonerotic contact. Accordingly, null Hypothesis 6 was retained.

Question 10: Men and women did not differ in determining the benefits of erotic contact. The mean score for men was 1.14, and the standard deviation was .41. The mean score for women was 1.05, and the standard deviation was .24. The f-ratio of .70 does not indicate statistical significance of the 0.5 level. Thus, null Hypothesis 7 was retained.

Question 11: Men and women do not differ in the utilization of erotic contact with patients. The mean score for men was 1.14, and for women, 1.23. The standard deviations were .64 and .97 respectively. The f-ratio of .19 and was not significant at the .05 level. Therefore, null Hypothesis 8 was accepted.

Question 12: Male and female therapists did not differ in their attitudes regarding whether or not erotic contact might be misunderstood. The mean scores were 4.80 and 4.47 respectively. The standard deviation for men was .69 and for women, 1.23. The f-ratio of 1.76 does not indicate statistical significance at the .05 level. Therefore, null Hypothesis 9 remains as stands.
Question 13: This question deals with whether there are differences between men and women in the initiation of erotic contact. Question 13.a. demonstrates that there were no differences at all between the two groups. The means for both men and women were 1.00, with a standard deviation of 0.00, and an f-ratio of 0.

Question 13.b.: The mean scores for men were 1.76, and for women, 1.50. The standard deviations were 1.30 and 1.26 respectively. The f-ratio, .32, was non-significant at the .05 level. Men women do not differ in attitudes with regard to the initiation of erotic contact. Accordingly, null Hypothesis 10 was retained.

In summary, with regard to the hypothesis that male therapists will differ significantly from the female therapists, research Hypotheses 3 - 10 are rejected, and the null hypotheses are retained:

The male psychotherapists' responses do not differ significantly from the female psychotherapist's responses, on the indicated eight variables.

Research Hypotheses 11 - 18

The psychotherapists will differ significantly according to years in practice, on the preceding indicated eight variables.
Questions 5 - 18 and 10 - 13 were again treated with a one way analysis of variance. Table 6 provides the mean scores and the standard deviations for the years in practice. Results of testing Hypotheses 11 - 18 show that psychotherapists do not differ in their responses according to years in practice. Thus, for each of Hypotheses 11 - 18, the null hypothesis was retained, since no f-ratios exceeding the critical f-ratio of 3.15 with two between degrees of freedom was observed.

Question 5: There were little differences between the groups of therapists according to years in practice and the benefits of nonerotic contact. The mean score for 1 - 10 years in practice was 2.36, for 11 - 25 years 2.40, and for over 25 years 2.00. The standard deviations respectively were .92, 1.21, and 1.06. The f-ratio of .46 was non-significant at the .05 level. Thus, null Hypothesis 11 was retained.

Question 6: There were no differences between the groups of therapists with regard to the utilization of non-erotic contact. The mean score for 1 - 10 years was 2.16 and the standard deviation was .83. For 11 - 25 years in practice the mean score was 2.32 and the standard deviation was 1.21, and for over 25 years, the mean was 2.00 with a standard deviation of .92. The f-ratio of .36 was not significant at the .05 level. Accordingly, null Hypothesis 12 was accepted.
Question 7: The years in practice do not effect differences in attitudes in whether nonerotic contact will be misunderstood. The mean score for 1 - 10 years in practice was 3.43, for 11 - 15 years in practice was 3.25, and for over 25 years 3.87. The standard deviations were respectively 1.04, .96, and 1.12. The f-ratio of 1.18 was not significant at the .05 level. Thus, null Hypothesis 13 was upheld.

Question 8.a.: Years in practice do not effect differences among therapists and the initiation of nonerotic contact. The mean score for 1 - 10 years of practice was 2.52 with a standard deviation of 1.22. The mean scores for 11 - 25 years of practice was 2.43 with a standard deviation of 1.19. And the mean scores for therapists in over 25 years of practice was 1.83 with a standard deviation of .75. The f-ratio of .83, was not significant at the .05 level. Question 8.b.: The mean scores for 1 - 10 years in practice was 3.03, for 11 - 15 years in practice was 2.78, and for over 25, 2.83. The standard deviation for 1 - 10 years was 1.31, for 11 - 15 years, 1.27, and for over 15 years, 1.16. The f-ratio of .25 was not significant at the .05 level. Accordingly, null Hypothesis 14 remains.

Question 10: The groups of therapists do not differ according to years in practice with regard to the benefits of erotic contact. The mean score for 1 - 10 years in practice was 1.06 with a standard deviation of .25. The
mean score for 11 - 15 years in practice was 1.14 with a standard deviation of .36. The mean score for over 25 years in practice was 1.25 with a standard deviation of .70. The f-ratio of .80 was not statistically significant at the .05 level. Null Hypothesis 15 was therefore accepted.

Question 11: The groups of therapists do not differ according to years in practice with regard to the utilization of erotic contact with patients. The mean score for 1 - 10 years in practice was 1.00, for 11 - 15 years in practice, 1.32, and for over 25 years in practice, 1.25. The standard deviations respectively were 0.00, 1.05, and .70. The f-ratio of 1.46, was not significant at the .05 level. Null Hypothesis 16 remains as stands.

Question 12: The groups of therapists do not differ in whether or not erotic contact might be misunderstood. The mean score for 1 - 10 years of practice was 4.63 with a standard deviation of .88. The mean scores for 11 - 15 years in practice was 1.32 with a standard deviation of 1.05. And the mean scores for over 25 years in practice was 5.00 with a standard deviation of 0.00. The f-ratio of .492, was not significant at the .05 level. Therefore, null Hypothesis 17 remains accordingly.

Question 13.a.: Years in practice did not have any effect on determining the initiation of erotic contact. The question again demonstrated no difference between the groups tested. Question 13.b.: The mean score for 1 - 10 was 1.59,
for 11 - 15 years 1.52, and for over 25 years 2.80. The standard deviations were 1.22, 1.00, and 2.04 respectively. The f-ratio of 2.168 and proved to be not significant at the .05 level. Thus, null Hypothesis 19 is retained.

Therefore, years in practice do not have an effect on the responses to the questions regarding nonerotic and erotic contact. Thus, research Hypotheses 11 - 18 are rejected. Accordingly, null Hypotheses 11 - 18 were retained.

The psychotherapists will not differ significantly according to years in practice, on the indicated eight variables.
### Table 5
Mean Scores for Gender Differences

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean for Men</th>
<th>S.D.</th>
<th>Mean for Women</th>
<th>S.D.</th>
<th>F-ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>2.22</td>
<td>1.01</td>
<td>2.62</td>
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</tr>
<tr>
<td>6</td>
<td>2.12</td>
<td>.97</td>
<td>2.47</td>
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<td>3.29</td>
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<td>.28</td>
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<td>b.</td>
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<tr>
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<td>1.14</td>
<td>.41</td>
<td>1.05</td>
<td>.24</td>
<td>.70</td>
</tr>
<tr>
<td>11</td>
<td>1.14</td>
<td>.64</td>
<td>1.23</td>
<td>.97</td>
<td>.19</td>
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<td>4.47</td>
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<td>.0</td>
</tr>
<tr>
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### Table 6
Mean Scores for Years in Practice

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean Score</th>
<th>S.D.</th>
<th>Mean Score</th>
<th>S.D.</th>
<th>Mean Score</th>
<th>S.D.</th>
<th>F-ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>2.36</td>
<td>.92</td>
<td>2.40</td>
<td>1.21</td>
<td>2.00</td>
<td>1.06</td>
<td>.46</td>
</tr>
<tr>
<td>6</td>
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<td>.83</td>
<td>2.32</td>
<td>1.21</td>
<td>2.00</td>
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<td>7</td>
<td>3.43</td>
<td>1.04</td>
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<td>.96</td>
<td>3.87</td>
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<td>1.19</td>
<td>1.83</td>
<td>.75</td>
<td>.83</td>
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<tr>
<td>b.</td>
<td>3.03</td>
<td>1.31</td>
<td>2.78</td>
<td>1.27</td>
<td>2.83</td>
<td>1.16</td>
<td>.25</td>
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<tr>
<td>10</td>
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<td>1.14</td>
<td>.36</td>
<td>1.25</td>
<td>.70</td>
<td>.80</td>
</tr>
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<td>1.00</td>
<td>.0</td>
<td>1.32</td>
<td>1.05</td>
<td>1.25</td>
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<td>.0</td>
<td>1.00</td>
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<td>.0</td>
</tr>
<tr>
<td>b.</td>
<td>1.59</td>
<td>1.22</td>
<td>1.52</td>
<td>1.00</td>
<td>2.80</td>
<td>2.04</td>
<td>2.16</td>
</tr>
</tbody>
</table>

\( \omega \) = significant at the .05 level
Research Hypotheses 19 - 26

The psychotherapists' responses will differ significantly according to age, on the preceding indicated eight variables.

The means and standard deviations for Research Hypotheses 19 - 26 may be found in Table 7. Results of testing Research Hypotheses 19 - 26 show that the psychotherapists do not differ in their responses according to age. Thus, for each of Research Hypotheses 19 - 26, the null hypotheses were retained, since no f-ratios exceeding the critical f-ratio of 4.00 with one between group degrees of freedom was observed.

The variable of age was divided into three categories: under 30, 30 - 50, and over 50. There were fifty therapists in the 30 - 50 age group, and fifteen in the age group that was over 50. However, there was only one therapist in the under 30 age group. A one way analysis of variance cannot be performed with a subgroup of N=1, as there is no within cell variance for that group. Therefore, the under 30 group was not included in the analysis of variance. The mean scores for that one individual are provided in Table 7 for information purposes only.

Question 5: Age did not have any effect on whether therapists viewed nonerotic contact as beneficial in a therapy
practice. The mean score for the 30 - 50 group was 2.32, and for the over 50 age group, 2.13. The standard deviations were respectively 1.06 and 1.08. The f-ratio of .34, was not significant at the .05 level. Thus, null Hypothesis 19 was retained.

Question 6: There were no differences between the groups of therapists with regard to the utilization of nonerotic contact. The mean scores for the 30 - 50 group was 2.10 with a standard deviation of .87. The mean score for the over 50 age group was 2.46 with a standard deviation of 1.25. The f-ratio of 1.57, was not significant at the .05 level. Therefore, null Hypothesis 20 was accepted.

Question 7: There were no differences according to age with regard to whether nonerotic contact might be misunderstood. The mean score for the 30 - 50 age group was 3.46 and the standard deviation of 1.07. The f-ratio was not significant at the .05 level. Age does not have any effect on whether the psychotherapist believes that nonerotic contact may be misunderstood. Accordingly, null Hypothesis 21 remains.

Question 8.a.: The therapists did not differ by age with regard to the initiation of nonerotic contact. The mean score for the 30 - 50 age group was 1.98. The mean score for the over 50 age group was 1.80. The standard deviation for the 30 - 50 group was 1.39, and the over 50 group was 1.37. The f-ratio was .18 and was not significant at the .05 level.

Question 8.b.: The mean score for the 30 - 50 age group was
2.54 with a standard deviation of 1.59. The mean score for the over 50 age group was 1.93 and the standard deviation was 1.43. The f-ratio of 1.70 was not significant at the .05 level. Null Hypothesis 22 stands.

Question 10: Psychotherapists did not differ according to age in determining whether they consider erotic contact beneficial in a therapy practice. The mean score for the 30 - 50 age group was 1.06, and for the over 50 age group the mean score was 1.13. The standard deviations are .31, for the therapists 30 - 50, and .61, for the therapists who are over 50. The f-ratio of .37, was not significant at the .05 level. Thus, null Hypothesis 23 was retained.

Question 11: The therapists do not differ according to age and utilization of erotic contact. The mean score for the 30 - 50 age group was 1.10 with a standard deviation of .57. The mean score for the over 50 age group was 1.40, with a standard deviation of 1.08. The f-ratio of 1.91 was not significant at the .05 level. Thus, null Hypothesis 24 was accepted.

Question 12: The therapists did not differ in determining whether or not erotic contact might be misunderstood. The mean score of the therapists who are 30 - 50, was 4.58, with a standard deviation of 1.16. The mean score for the therapists who are over 50 was 3.86, with a standard deviation of 1.92. The f-ratio of 2.98, was not significant at the .05 level. Accordingly, null Hypothesis 25 was retained.
Question 13.a.: The psychotherapists did not differ significantly in their responses in the initiation of erotic contact. The mean score for the 30 - 50 age group was .74. The mean score for the over 50 group was .66. The standard deviations respectively are .43 and .47. Question 13.b.: The mean score for the 30 - 50 age group was 1.06, with a standard deviation of 1.07. The mean score for the over 50 group was .1.28, with a standard deviation of 1.66. The f-ratio of .34, was not significant at the .05 level. Thus null Hypothesis 26 was retained.

Therefore, the premise that psychotherapists will differ significantly according to age was found to be not true with regard to all of the research hypotheses. Thus, Research Hypotheses 19 - 26 are rejected, and null Hypotheses 19 - 26 were retained:

The psychotherapists did not differ according to age on the preceding eight variables.
Research Hypotheses 27 - 34

The married psychotherapists' responses will differ significantly from the nonmarried psychotherapists' responses, on the preceding eight variables.

The final grouping of hypotheses were also analyzed with a one way analysis of variance. Table 7 presents the mean scores with standard deviations for the psychotherapists according to marital status. Results of testing research Hypotheses 27 - 34 show that married psychotherapists and nonmarried psychotherapists do not differ in their responses regarding nonerotic and erotic contact with their patients. Thus, for each of Hypotheses 27 - 34, the null hypothesis was retained, since no f-ratios exceeding the critical f-ratio of 4.00 with one between degrees of freedom was observed.

Question 5: There were little differences between the married therapists and the not married therapists and the attitudes regarding the benefits of nonerotic contact. The mean score for the not-married was 2.36, with a standard deviation of 1.06. The mean score of the married group was 2.20 with a standard deviation of 1.13. The f-ratio of .19, was not significant at the .05 level. Thus, null Hypothesis 27 was retained.

Question 6: There were no differences between the
groups of therapists with regard to the utilization of non-erotic contact. The mean score for the not-married was 2.20 and the married mean score was 2.27. The standard deviation for the not-married group was 1.27, and for the married therapists it was .96. The f-ratio, .04, was not significant at the .05 level. Accordingly, the null Hypothesis 28 is accepted.

Question 7: In determining whether or not nonerotic contact might be misunderstood, the married and the not married therapists do not differ in their responses. The mean score for the not married therapists was 3.43, and the married group, 3.27. The standard deviations were .90, and 1.04 respectively. The f-ratio of .23, was not significant at the .05 level. Thus, null Hypothesis 29 remains.

Question 8.a.: Therapists do not differ according to marital status in determining the initiation of nonerotic contact. The mean score for the not married therapists was 2.45, and the standard deviation was .91. The married therapists' mean score was 2.20 with a standard deviation of .37. The f-ratio was .37 and was not significant at the .05 level. Question 8.b.: The mean score for the married therapists was 2.70 with a standard deviation of 1.31. The not married therapists demonstrate a mean score of 2.95 and a standard deviation of 1.05. The f-ratio, .32, was not significant at the .05 level. Accordingly, null Hypothesis 30 remains.

Question 10: There were little differences in the married and the not married therapists with regard to the ex-
pected benefits of erotic contact. The mean score for the married therapists was 1.14, with a standard deviation of .40. The not married therapists' mean score was 1.00, with a standard deviation of 0.0. The f-ratio of .32, was not significant at the .05 level. Thus, the null Hypothesis 31 was upheld.

Question 11: Married and not married therapists do not differ in their attitudes regarding the utilization of erotic contact. The mean score for the not married therapists was 1.12 and for the married therapists the mean was 1.36. The standard deviations were 1.20 and .61 respectively. The f-ratio of .94 was not significant at the .05 level. Null Hypothesis 32 was retained.

Question 12: The married and the not married therapists do not differ in attitudes of whether erotic contact might be misunderstood. The mean score for married therapists was 4.54 and the standard deviation was .79. The mean score for the not married therapists was 4.74 with a standard deviation of 1.21. The f-ratio of .46 and was not significant at the .05 level. Therefore, null Hypothesis 33 was retained.

Question 13.1.: Married and not married therapists do not differ in their responses regarding the initiation of erotic contact. There were no differences between the two groups tested with regard to question 13.2. Question 13.b.: The mean score for the married was 1.62, and for not married therapists, 1.72. The respective standard deviations were 1.27 and 1.40. The f-ratio of .03 and is not significant at
the .05 level. Accordingly, null Hypothesis 34 was accepted.

The married and the not married psychotherapists did not differ in their attitudes and practices with regard to research Hypotheses 27 - 34. Interestingly, question 13.a. has continuously shown no differences in the responses between the groups. The psychotherapists do not differ in their views of whether they as therapists are initiators of erotic contact. Research Hypotheses 27 - 34 did not show any observable differences present according to marital status. In conclusion, Hypotheses 27 - 34 are rejected, and the null Hypotheses were accepted:

The married psychotherapists' responses do not differ significantly from the non-married psychotherapists' responses, on the indicated eight variables.
Table 7

Mean Scores for Age Differences

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean Score</th>
<th>S.D.</th>
<th>Mean Score</th>
<th>S.D.</th>
<th>Mean Score</th>
<th>S.D.</th>
<th>F-ratio</th>
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<tr>
<td></td>
<td>under 30</td>
<td>30-50</td>
<td>50 and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
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<td>1.00</td>
<td>2.12</td>
<td>1.08</td>
<td>.34</td>
</tr>
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<td>8.a.</td>
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<td>.37</td>
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<tr>
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<td>3.86</td>
<td>1.92</td>
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<td>.66</td>
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<td>.30</td>
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Table 8

Mean Scores for Marital Status

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<tr>
<th>Variable</th>
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<th>S.D.</th>
<th>F-ratio</th>
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<tr>
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<td></td>
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<td>1.22</td>
<td>.37</td>
</tr>
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<td>.40</td>
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</tr>
<tr>
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<td>1.20</td>
<td>1.36</td>
<td>.61</td>
<td>.94</td>
</tr>
<tr>
<td>12</td>
<td>4.74</td>
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<td>.46</td>
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<tr>
<td>13.a.</td>
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<td>1.00</td>
<td>.0</td>
<td>.0</td>
</tr>
<tr>
<td>b.</td>
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<td>1.62</td>
<td>1.27</td>
<td>.03</td>
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</table>

α significance at the .05 level
Discussion of Results

The study revealed that the attitudes of the psychotherapists that responded to the questionnaire were most consistent with their actual practices. This was true of both nonerotic and erotic contact.

Only one psychotherapist out of sixty-six reported sexual involvement. This respondent was a married male, in the 30 - 50 age range, of 11 - 25 years experience. He explained that the contact would have occurred "regardless of the context" and that the contact was based on "Love: full, deep, forever." Regarding actual contact, a percentage of 1.5% is quite low, considering the evidence that intimate contact between psychotherapist and patient occurs more frequently than is suspected (Shepard, 1971).

Generally, the respondents' answers on the questionnaire items regarding nonerotic and erotic contact tended to be quite conservative. The mean score for the total population with standard deviations may be found in Table 9.

The majority of responses to the question of nonerotic contact; is it beneficial, and does the therapist use it, continually fell in the never to rarely range. It was most often stated that nonerotic contact was generally limited to a "warm handshake". The handshake was used in greeting, leavetaking, or in termination. One psychotherapist was able to distinguish at exactly what time frame a handshake might occur. "I frequently shake hands with patient on 12th
meeting" or "on return from a long absence".

There were a small number of therapists who clarified nonerotic contact as "a spontaneous expression of joy or sorrow". And more clearly, it was used in "building self esteem; positive body image; trust building; non-verbal communication; and assessment of client's non-verbal communication styles". It was also found to be helpful with children, "To re-parent; to show children affection". Non-erotic behavior was used in "reassuring" and to help "same sex clients become comfortable with physical closeness". Interestingly, that contact was also of benefit in helping "to break through to more soft feminine layers in men". And finally, one psychotherapist stated it was to be used "as an expression of comfortable human caring when it would clearly be ridiculous and awkward not to."

Rarely, where the answers delineated as a means of "sympathy or support". Few therapists used it in treatment of "severely isolated or schizophrenic patients".

Regarding the attitudes and practices of erotic contact it was the general consenses that "erotic contact is unethical". And it was stated that "stud therapy is a poor excuse for incompetence". Most therapists responded that "because of the vulnerable position that clients are often in, it is highly unethical for therapists to engage in erotic contact". Many therapists stated that a psychotherapist is seen as a "parent-surrogate", therefore, contact between patient and therapists
is seen "similar to incest".

One therapist stated that erotic contact would be of benefit "when the patient and therapist need to discover the nature of significance they attach to the body and special relationships." Additionally, the other times when erotic contact was beneficial was during "sexual dysfunction" or that it be used to "uncover latent material surrounding erotic events in client's life". In most of these cases it was suggested that the use of a "sexual surrogate" be retained.

Generally, erotic contact was seen as "exploitive and destructive for the patient". "When sexual contact does occur between therapists and the patient it is a reflection of unsolved personal problems on the part of the therapist..."

Many therapists stated that they had "picked up the pieces for several clients following contact with previous therapists", and "all had negative impacts".

One therapist finalized the situation with, "one cannot do any professional work, particularly psychotherapy without objectivity. Being objective and being sexually involved are usually contradictory, are they not? A good psychotherapist stands on the sidelines (figuratively) like a coach - he cannot play the game for or with the patient".

It was interesting that throughout the years of practice, patients were viewed as being more likely to initiate contact; therapists consistently reported not initiating contact. The one therapist who reported intercourse, with one patient, was
found to initiate contact less than 5% of the time.

Age difference was found to be an interesting variable. There was one therapist under 30. The therapist was female, married and in practice for under 10 years. She was found to be the most liberal in views. The therapist consistently believed in and utilized nonerotic contact. And she stated further, that it was rarely misunderstood. Contact was initiated mutually by therapist and patient on a frequent basis. She also reported that erotic contact was beneficial rarely, and it was never utilized and nearly always misunderstood. Interestingly, it was never initiated by the therapist and nearly always by the patient.

In comparison, the benefits of nonerotic contact were viewed more conservatively by older therapists, and yet utilized more than their stated views would suggest. The therapists who were 30 - 50 thought that nonerotic contact might be more misunderstood, and yet utilized and initiated contact. Their patients as well initiated more contact than the patients of older therapists. In contrast, the older therapists viewed erotic contact as more beneficial and utilized erotic contact more frequently than younger therapists, although still at a low level. Older therapists also stated that it was less misunderstood than the therapists in the 30 - 50 age group. Again, all therapists were consistent regarding whether the therapists initiated contact - never!
The mean scores for the not-married were consistently higher than those of the therapists that were married. Except for the questions of the utilization of nonerotic and erotic contact, the married therapists means were found to be higher than the not married. Thus, while their belief in the anti-therapeutic aspect of nonerotic and erotic contact is strong, they actually had more occasion to use the contact. It was further discovered that patients initiated contact more frequently with therapists who were not married than those of the therapists who were married.

The results of the study show that the population of psychotherapists in Palo Alto, California, are consistent in their attitudes and practices regarding sexual intimacy with patients. The population demonstrates a conservative consistency in that nonerotic contact is seen as rarely of benefit, and rarely utilized.

Similarly, the attitudes of the psychotherapists were also consistent and conservative regarding erotic contact. Erotic contact was most often found never to be of benefit, and it was most often never utilized. The one therapist who utilized erotic contact was male, 30 - 50, married, and in practice for 11 - 25 years.
Table 9
Mean Scores for the Total Population

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean Score Total Population</th>
<th>Standard Deviation</th>
</tr>
</thead>
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<td>b.</td>
<td>1.70</td>
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Chapter V
CONCLUSIONS AND RECOMMENDATIONS

Summary
The purpose of this study was to assess the attitudes and practices of psychiatrists and psychologists regarding erotic and nonerotic contact with patients. A dual aim was to determine if there was a relationship between the attitudes involving contact with patients and the actual practices of the psychiatrists and psychologists.

In a survey of the population of psychotherapists in Palo Alto, California, it was found that the attitudes regarding nonerotic contact were significantly related to the actual practices of the nonerotic contact of the psychotherapists. It was further discovered, that the attitudes of the psychotherapists regarding erotic contact were consistent, and significantly related to the actual practices of erotic contact of the psychotherapists.

The population sampled totaled 135. Out of the 135 sampled, sixty-seven responded with a completed questionnaire. One response was declared unusable, as neither the gender, nor the years in practice was completed.

Therefore, the response totaled sixty-five. This was a response rate of almost 50%.

Thirty-four hypotheses were tested statistically. Hypotheses 1 and 2 were analyzed with a one way analysis of
Two of the research hypotheses were retained: Hypotheses 1 and 2. The remaining 32 research hypotheses were rejected. The latter hypotheses were related to determining differences in responses for the psychotherapists with regard to age, gender, marital status, and years in practice. It was found that these variables had little, if any, effect on the psychotherapists' attitudes and practices regarding nonerotic and erotic contact with patients.

It was also discovered that the attitudes revolving around nonerotic contact, and erotic contact were viewed more liberally by women, than by men. Yet, the actual practice of nonerotic and erotic contact was engaged in more by men than by women. In the entire population sampled, only one psychotherapist reported sexual involvement. That therapist was limited to one patient.

Most often the views of the psychotherapists suggested outrage at the topic, and great concern that the topic is a much needed area of research. Many of the therapists reported treating patients that had been victims of other therapists. In summary, one psychotherapist presented a clear, concise statement which seemed to consolidate many of the Palo Alto therapists' views:

"I have treated patients who have had sexual relations with previous therapists. In these cases, the results had been clearly antitherapeutic. The
emotional aftermath was akin to that of a rape victim's, only somewhat more subtle and insidious. The resistance against disclosing and openly facing any emotionally loaded material was greatly increased. At best, having sex with patients is acting out in the countertransference, and at worst, it is simply self-indulgence at the expense of a very vulnerable person.

In conclusion it was found that in the population of psychotherapists in Palo Alto, California, intimacy between therapist and patient is quite uncommon.

Limitations

The results of the study proved to be generally quite consistent. The population is generally viewed as quite conservative. This may have had an effect on the results of the study. The response rate was not quite 50%, therefore the results may, or may not be, representative of the population of psychotherapists in Palo Alto.

The questionnaire was supplied to the psychotherapist via the mail service. Likewise, the questionnaire was to be returned to the researcher through the mail service, which may have hampered the response rate. The psychotherapists were given ten days to complete the questionnaire. Because there was a holiday weekend during the response period, some
therapists may have already been away for the holiday weekend. Additionally, the deadline for the questionnaires occurred within the summer months. Psychotherapists may have been vacationing, and this again may have influenced the results.

It is difficult to determine how much the sensitivity of the topic influenced data collected. It is safe to assume that few therapists will be explicit in outlining the extent of their contact with patients. This appeared to be the case with both nonerotic, and erotic contact. However, with regard to the assessment of attitudes, it was thought that the therapists would not be quite as conservative as indicated.

Several of the respondents indicated that the questionnaire was difficult to answer. Some psychotherapists found the questions misleading, or much too broad in nature, for them to answer them adequately. Therefore, the presentation and format of the questionnaire may have influenced the results indicated, and the response rate.

Recommendations
1. It is recommended that there be changes in research methodology. It is difficult to assess erotic and nonerotic contact between patient and therapist. The therapists that are the subjects of study may possibly fear public and professional recriminations. Despite the fact that these studies are held to be completely anonymous, the fear of these recriminations may influence the respondents' answers. This factor presents
a collection of data that may in fact be biased. It is therefore suggested that greater acknowledgement by professional associations, surrounding colleagues, and the public, regarding the topic of sexual intimacy between patient and therapist be generated. Greater acknowledgment may be accomplished in a number of ways.

1.) Seminars could be held at the conferences sponsored by local, state and nationally know therapeutic associations and organizations.

2.) The annual meetings of these associations and organizations should include an update in the field on the topic of sexual intimacy between therapist and patient.

3.) Clinics should be made available to therapists who hold this as an area of concern.

4.) There should be a great amount of support and encouragement by colleagues for the therapists who are concerned with this problem.

2. It is further recommended that there be more research. At the local level, a follow-up study may be indicated. Therapists' attitudes may change over the coming years. California, especially the Bay Area, is quite generally a liberal area. As politics and society change, it is important to keep abreast of the changing attitudes of therapists. Further studies could
be sponsored by:

1.) The local psychological association.
2.) The local medical society.
3.) The local county health services.
4.) The county mental health agencies.
5.) The local educational institutions.

3. Finally, the seminars and clinics that were discussed in Recommendation 1, should be made available in training institutions. Sexual intimacy between therapists and patients, and the ethical concerns involved, should be included as part of course requirements at the masters and doctoral levels. Additionally, this topic should be included as part of psychiatric training.
BIBLIOGRAPHY
BIBLIOGRAPHY


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APPENDIX A


APPENDIX B
Dear Doctor:

Whether it be for legal, ethical, or treatment reasons, an area of great concern to psychiatrists and psychologists is the question of intimacy with clients. Despite that, the last major study was completed in 1975 and sampled southern California physicians. There have been no similar studies done of physicians or psychologists in northern California.

As a graduate student in Clinical counseling at California State University at Hayward, I have become increasingly aware of this as a professional problem to be faced as a practicing therapist. Therefore, I have elected to research this topic as my master's thesis. Please see my advisor's endorsement at the bottom of the page.

To begin study of the topic of intimacy, I am conducting a survey of the attitudes of psychiatrists and psychologists in Palo Alto, California. The views of all licensed psychiatrists and psychologists in this community are being sought.

Your participation in this study is invited. Enclosed please find a one page questionnaire, which should take less than ten minutes of your time. This questionnaire may initially shock or offend some people. Please do not be offended. It is an honest attempt to conduct an objective exploration of a significant, if sensitive, area of professional practice.

This questionnaire, and your responses, will remain completely anonymous. To facilitate and expedite your participation, an enclosed return envelope is provided. Please return the questionnaire by July 5, 1980. I will be happy to share the results of the study. If you would like to receive such, please send your address on the enclosed post card. Thank you for your cooperation.

Sincerely,

Peri L. Pitcock Mosley

Please be assured that Ms. Mosley's study is being conducted as part of her formal program with us and is proceeding with full academic supervision. Your response will be much appreciated.

Robert M. White, Ph.D.
Professor
Educational Psychology