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Ethics Among Christian Counselors: A Survey of Beliefs and Behaviors

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Previous researchers have reported survey results of the beliefs and behaviors of psychologists (Pope, Tabachnick, & Keith-Spiegel, 1987) and counselors (Gibson & Pope, 1993) with regard to professional ethics. We sent the same instrument to 900 Christian counselors, and received back 496 completed surveys. Rarely and commonly practiced ethical behaviors are described, and differences by sex, age, highest degree, and licensure status are discussed. Although Christian counselors generally appear to have high regard for and good awareness of ethical standards, many unlicensed Christian counselors may benefit from additional training in preventing exploitative counseling relationships. Current professional standards for multiple-role relationships may not apply well to all Christian counseling situations, making an ethics code for Christian counselors an important goal for the immediate future. Implications for training paraprofessionals and for subsequent research are considered.

As counseling has moved away from the rationalist and positivist approaches often associated with anti-religious sentiments, and toward the postmodern, constructivist approaches, religious forms of mental health care have increased in popularity (Bergin, 1980, 1991; Jones, 1994): Several visible journals pertain to the integration of religion and psychology; Division 36 of the American Psychological Association (APA) exists to enhance understanding of religious issues in psychology; an increasing number of regionally-accredited institutions with distinctively Christian mission statements offer doctoral degrees in psychology; and two national organizations for Christian mental health professionals are flourishing.

With religious forms of therapy gaining popularity, the qualifications of service providers are also evolving. Within a religious community, for example, a pastor, pastoral counselor, or lay counselor may have more credibility than a licensed psychologist or psychiatrist (McMinn, 1991; Quackenbos, Privette, & Klentz, 1985). Thus, Christian counseling is often a mix of professional, clergy, and peer caregivers.

In the midst of changes in religiously-oriented mental health services, many questions regarding awareness of and sensitivity to ethical standards must be addressed. For example, Craig (1991) reported that only ten percent of the members of the American Association of Marriage and Family Therapists (AAMFT) are clergy counselors, yet clergy counselors accounted for 75% of the licensure revocations in a recent year.

Just as other mental health professions have emphasized systematic research in establishing ethical standards by which a profession regulates itself (Gibson & Pope, 1993; Pope et al., 1987), religiously-oriented counselors must also establish a scientific base for understanding what beliefs and behaviors are common and uncommon and how those beliefs and behaviors affect their counseling work.

The American Association of Christian Counselors (AACC) is in the process of developing an ethics code—a process which poses at least two challenges. First, there is a dearth of data regarding the ethics beliefs and behaviors of Christian counselors. Pope et al. (1987) reported the results of a survey of 456 members of the American Psychological Association, but it is unclear what portion of those respondents identified themselves as religious. Gibson and Pope (1993) surveyed 579 nationally-certified counselors, using a similar survey instru-

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ment, but again the religious values of participants were not assessed. Oordt (1990) reported the beliefs and behaviors of Christian psychologists, but the results are limited by including only psychologists in the study, and by the small sample size ($N = 69$) and poor response rate (35%).

Second, the AACC ethics code poses unique challenges because of the diversity of its members. Some members have graduate degrees and professional counseling licenses, whereas others are church-based lay counselors with no formal graduate training. Although a significant amount of attention has been given to the relative effectiveness of paraprofessional counselors (see Christensen & Jacobson, 1994), there is no published information about the ethical sensitivity of paraprofessional therapists. This study represents an effort to provide initial information about the ethics beliefs and behaviors of professional and paraprofessional Christian counselors.

Method

Participants

Participants for the study were randomly selected from the membership list of the AACC. Three hundred with doctoral degrees, three hundred with masters degrees, and three hundred with no graduate degree were selected. Of the 900 individuals to whom surveys were sent, 29 returned personal responses explaining why they could not complete the survey (e.g., retirement, not currently practicing), and 5 were undeliverable. Of the 866 who could have responded, 496 returned completed or partially completed surveys, resulting in a return rate of 57%.

Materials

The survey questionnaire was based upon the survey instrument used by Pope et al. (1987), and was divided into three main sections. First, participants responded to a list of 88 behaviors by reporting how often they engaged in the behavior and whether or not they believed it was ethical. Pope's et al. (1987) list included 82 behaviors, with one item being repeated to allow for a reliability check. Gibson and Pope (1993) added five behaviors at the end of the original 83 and replaced the repeated item, resulting in a total of 88 items. These same 88 items were used in this survey, except that we retained the repeated item (#66 and #82: "Being sexually attracted to a client") rather than using Gibson and Pope's (1993) replacement item for #66 ("Advertising accurately your counseling techniques"). Frequency of engaging in the behavior was rated on a five-point scale: never, rarely, sometimes, fairly often, or very often. Participants also had an option of reporting that a behavior was not applicable to their counseling practice. Beliefs about the ethics of the behavior were also rated on a five-point scale: unquestionably not, under rare circumstances, don't know/not sure, under many circumstances, and unquestionably yes.

Second, participants evaluated the usefulness of 14 resources for providing direction and regulation of their practice. These included resources such as graduate training, internship, state ethics committees, and so on. Usefulness for each was assessed on a five-point scale: terrible, poor, adequate, good, and excellent. Participants also had the option of reporting that a resource was not applicable to their situation. This portion of the survey was used as part of a separate study and is reported elsewhere (McMinn & Meek, in press).

Third, participants reported demographic and professional information including their sex, age, primary work setting, major theoretical orientation, organizational memberships, highest degree held, and number of professional journals received. They also rated the prevalence of several different psychiatric disorders among those for whom they provide services—information used as part of a separate study that is reported elsewhere (McMinn & Wade, 1995).

Procedure

Surveys were sent in March, 1994, with a cover letter describing the purpose of the study, and participants were asked to put their completed survey in an inner envelope which, in turn, was placed in an outer postage-paid envelope. The outer envelope was sent to a psychologist in Oregon who separated the inner and outer envelopes and then sent them to the primary investigators in Illinois. The outer envelopes had a code to identify who had returned the survey, but since the inner envelopes had been previously separated, none of the survey responses could be traced to individual respondents. This assured confidentiality for those completing the survey. Those who had not yet returned the survey after three weeks were sent a reminder postcard. After two additional weeks, they were sent another questionnaire packet.

Results

Of the 496 respondents, 300 (60.5%) were male, 180 (36.3%) were female, and 16 (3.2%) did not report their sex. Approximately 80% were between the ages of 30 and 60 years, and another 17% were over 60 years. Seventy-one (14.3%) respondents reported having no graduate degree, 228 (46.0%) reported having a master's degree as their highest degree, and 170 (34.3%) a doctoral degree. Almost one-third of the respondents (n = 162) reported a private office as their primary work setting, and another 148 (29.8%) reported a church as their primary work setting. Other primary work settings included clinics (n = 40), hospitals (n = 14), universities (n = 13), and various other settings (n = 68). Less than one-third (n = 152; 30.6%) reported having a license in a mental health profession.

Response patterns to each of the 88 items were computed for both the behavior rating scale and the belief rating scale. Items that were commonly or rarely endorsed are listed in Table 1. Commonly endorsed behaviors are those that at least 90% of the respondents reported engaging in, at least rarely. Commonly endorsed beliefs are those that at least 90% of the respondents reported to be ethical, at least on rare occasion. Conversely, rarely endorsed behaviors and beliefs were never engaged in or viewed as always unethical by at least 90% of the respondents. A complete listing of response patterns to each item can be found elsewhere (McMinn, Meek, & McRay, in press).

Differences in response patterns were evaluated based on the respondents' sex, age, highest degree, and professional license. In each case chi-square analyses were computed for each of the 88 behaviors and beliefs. Because of the large number of analyses and the possibility of Type I error, a very stringent level of significance ($p < .001$) was set. This is consistent with the procedure used by Pope et al. (1987). Sex differences were found on 8 of the 88 behaviors and 4 beliefs. Age differences were found for 1 behavior and 6 beliefs. Differences by highest degree were found on 5 behaviors and 5 beliefs. Finally, differences were found between licensed and unlicensed counselors on 13 behaviors and 14 beliefs. The specific beliefs and behaviors on which differences were found are listed in Tables 2 and 3.

Discussion

Interpretive Concerns

Several limitations to survey methods in general, and to this study in particular, should be considered in interpreting these results. First, there is a possibility that the 43% who did not return their surveys differ in significant ways from the 57% who returned surveys. Second, a related concern is that AACC members may not accurately reflect Christian counselors in general, many of whom do not belong to AACC. Third, interpretation of these results is complicated by the diversity of the sample. Whereas previous surveys have tested the beliefs and behaviors of relatively homogeneous groups of professionals (Gibson & Pope, 1993; Oordt, 1990; Pope et al., 1987), this survey includes a variety of counselors ranging from doctoral level psychologists to lay counselors. This may be especially problematic in the discussion of group differences that follow. Because the survey response patterns require nonparametric analyses, we have not identified possible interaction effects between groups. For instance, it may be that certain combinations of gender and age would reveal differences that are masked by our more global analyses. Fourth, the respondents' reported behavior may not always reflect their actual behavior. For example, one might practice outside of a competency area without realizing it, and therefore would not report it as an ethical problem. Fifth, this is intended as a descriptive look at ethics beliefs and behaviors and not as a prescriptive tool for forthcoming ethics codes for Christian counselors. Although subsequent codes and revisions of existing ethics codes may draw upon these data, these results are properly seen as a reflection of current beliefs and behavior and not as evidence for what is prudent behavior. The goal of this research was not to determine what Christian counselors should believe and how they should behave, but rather to better understand actual beliefs and behaviors. Finally, our very stringent level of significance ($p < .001$) was used to minimize the risk of Type I errors, but it should be noted that this increases the risk of Type II errors. Thus, several differences between counselors of varying age, sex, graduate degree, and licensure status may exist but not be reported or discussed here.

Common Behaviors and Beliefs

There were five behaviors that at least 90% of those surveyed indicated that they have engaged in,

at least on rare occasion. All five behaviors pertain to the nature of the therapeutic relationship: "Using self-disclosure as a therapy technique," "Addressing your client by his or her first name," "Having a client address you by your first name," "Offering or accepting a handshake from a client," and "Hugging a client." This suggests that the majority of Christian counselors seek to establish a collaborative environment in which to bring about healing. These types of interactions, though not appropriate in every situation, can lend balance to counseling relationships that otherwise might be patronizing and hierarchical.

In addition to these five almost universal behaviors, 12 additional behaviors were believed to be ethical, at least on rare occasions, by 90% or more of the respondents whether or not they had actually engaged in them. Four pertain to issues of confidentiality: "Breaking confidentiality if client is homicidal," "Breaking confidentiality if client is suicidal," "Breaking confidentiality to report child abuse," and "Utilizing involuntary hospitalization." Christian counselors appear to be aware of their ethical responsibility to break confidentiality in situations where there is a clear and imminent danger to an individual or society (Brosig & Kalichman, 1992; Jobes & Berman, 1993; Monahan, 1993).

Christian counselors also seem to be sensitive to those who are in need of psychological services, yet are unable to afford them. Approximately 95% said that they believed it to be ethical, at least in rare circumstances, to provide therapy at no charge to the client. Furthermore, over three-fourths said that they have engaged in this practice, as compared to two-thirds of the psychologists surveyed by Pope et al. (1987).

There were two items that 90% of the respondents indicated to be ethical, at least rarely, yet a closer look indicates some ambivalence. Although only 7% said that advertising in newspapers or similar media is unquestionably unethical, 17% said they did not know. When asked about the ethics of earning a salary which is a percentage of client fees, only 10% said that it was unquestionably unethical while 30% said they did not know. This indicates a need for more education in areas involving certain financial practices. The remaining items endorsed as ethical by at least 90% of those surveyed were an assorted group: "Filing an ethics complaint against a colleague," "Going to a client's special event," "Joining a partnership that makes clear your specialty," "Crying in the presence of a client," and "Using a computerized test interpretation service."

Rare Behaviors and Beliefs

There were 24 behaviors that at least 90% of the Christian counselors reported that they had never engaged in while providing therapy. Of these 24 behaviors 10 were sexual in nature: "Telling client: 'I'm sexually attracted to you'," "Using sexual surrogates with clients," "Leading nude group therapy or 'growth groups'," "Becoming sexually involved with a former client," "Kissing a client," "Engaging in erotic activity with a client," "Engaging in sex with a clinical supervisee," "Engaging in sexual contact with a client," "Allowing a client to disrobe," and "Disrobing in the presence of a client." Interestingly, although these 10 behaviors were almost never practiced by the respondents, 4 of the 10 were considered ethical under some circumstances by more than 10% of the sample: "Expressing feelings of sexual attraction to a client" (77% said unethical), "Using sexual surrogates with a client" (84% said unethical), "Becoming sexually involved with a former client" (87% said unethical), and "Kissing a client" (82% said unethical). Those behaviors that were considered to be unquestionably unethical for at least 90% of the respondents were ones in which client harm appears to be more overtly obvious than in these 4 items. This trend is not limited to Christian counselors as other surveys have reported similar findings. Pope et al. (1987) found that only 52% of psychologists believed expressing feelings of attraction to a client is unethical, just 36% thought the use of sexual surrogates is always unethical, 50% believed that becoming sexually involved with a former client is always unethical, and only 48% reported that kissing a client is always unethical. Overall, it appears that Christian counselors are very sensitive to the importance of maintaining cautious standards with regard to sexual contact with their clients.

Of the remaining items that 90% of the respondents reported never having engaged in, four involved financial practices ("Giving gifts to those who refer clients to you," "Using a law suit to collect fees from a client," "Getting paid to refer clients to someone," and "Not disclosing your fee structure to a client"), and four involved dual role relationships ("Giving a gift worth at least $50 to a client," "Going into business with a client," "Borrowing money from a client," and "Going into business with a former client"). The majority of the Christian counselors surveyed have never made a custody evaluation with-

Table 1

Percentage of Christian counselors responding in each category to rare and common beliefs and behaviors

Survey Item	Rating									
	Occurrence in your practice?					Ethical?				
	1	2	3	4	5	1	2	3	4	5
COMMON BELIEFS AND/OR BEHAVIORS										
2. Charging a client no fee for therapy	15	31	28	9	18	4	34	8	22	31
4. Advertising in newspapers or similar media	55	15	18	6	6	7	10	17	27	39
6. Filing an ethics complaint against a colleague	76	19	4	0	0	6	25	7	17	45
8. Using a computerized test interpretation service	30	18	28	15	9	4	8	12	30	46
9. Hugging a client	10	34	34	17	5	4	44	6	36	11
18. Breaking confidentiality if client is homicidal	29	21	16	8	26	3	8	3	12	73
20. Using self-disclosure as a therapy technique	6	22	45	18	9	2	26	8	40	23
27. Breaking confidentiality if client is suicidal	12	19	23	13	33	3	8	4	12	74
32. Breaking confidentiality to report child abuse	14	17	25	13	31	4	7	1	12	76
34. Addressing your client by his or her first name	2	2	6	17	73	2	3	3	24	68
35. Crying in the presence of a client	25	46	23	3	2	8	37	11	25	19
36. Earning a salary which is a % of client fees	55	6	12	5	21	10	7	30	20	33
52. Having a client address you by your first name	5	10	17	17	51	4	9	9	22	55
59. Going to client's special event (e.g., wedding)	20	62	29	6	3	5	46	10	24	16
63. Utilizing involuntary hospitalization	33	44	17	4	2	6	40	10	18	25
77. Offering or accepting a handshake from a client	1	1	10	23	65	2	1	2	18	76
88. Joining a partnership that makes clear your specialty	45	10	18	9	17	6	4	12	19	59
RARE BELIEFS AND/OR BEHAVIORS										
15. Telling client: "I'm sexually attracted to you."	94	5	0	0	0	77	14	3	2	4
31. Using sexual surrogates with clients	98	1	0	0	1	84	3	7	1	4
38. Making custody evaluations without seeing the child	92	6	1	0	0	70	17	7	1	4
39. Accepting a client's decision to commit suicide	94	3	2	0	1	83	8	3	1	5

Table 1 continues next page

Table 1 *(continued)*
Percentage of Christian counselors responding in each category to rare and common beliefs and behaviors

Survey Item	Rating									
	Occurrence in your practice?					Ethical?				
	1	2	3	4	5	1	2	3	4	5
RARE BELIEFS AND/OR BEHAVIORS (continued)										
41. Leading nude group therapy or "growth groups"	99	0	0	0	0	91	3	3	1	3
45. Giving gifts to those who refer clients to you	90	6	2	1	1	65	13	14	5	4
46. Using a law suit to collect fees from a client	90	7	2	0	0	34	29	22	5	10
47. Becoming sexually involved with a former client	98	0	0	0	0	87	7	2	0	3
54. Kissing a client	92	7	1	0	0	82	12	2	2	3
55. Engaging in erotic activity with a client	99	1	0	0	0	96	0	0	0	4
56. Giving a gift worth at least $50 to a client	93	4	2	0	0	79	12	5	1	3
58. Engaging in sex with a clinical supervisee	100	0	0	0	0	96	0	0	0	3
60. Getting paid to refer clients to someone	96	2	2	0	0	77	7	9	2	4
61. Going into business with a client	95	5	0	0	0	74	14	8	2	3
62. Engaging in sexual contact with a client	98	2	0	0	0	95	1	0	0	3
68. Allowing a client to disrobe	98	1	0	0	0	93	3	0	0	3
69. Borrowing money from a client	99	1	0	0	0	93	3	1	0	3
70. Discussing a client (by name) with friends	93	7	0	0	0	92	4	0	0	4
72. Signing for hours a supervisee has not earned	97	2	1	0	0	94	1	1	0	3
74. Doing therapy which under the influence of alcohol	99	1	0	0	0	94	2	1	0	3
78. Disrobing in the presence of a client	100	0	0	0	0	96	0	0	0	3
80. Going into business with a former client	91	7	1	0	0	48	30	15	3	5
84. Not disclosing your fee structure to a client	90	6	2	0	2	80	8	5	1	6
86. Disclosing a name of a client to a class you are teaching	99	0	0	0	0	94	2	0	1	3

Notes. Rows may not sum to 100% because of rounding. Percentages were computed after removing missing data. For occurrence in your practice?: 1 = never, 2 = rarely, 3 = sometimes, 4 = fairly often, and 5 = very often. For ethical?: 1 = unquestionably not, 2 = under rare circumstances, 3 = don't know/not sure, 4 = under many circumstances, and 5 = unquestionably yes.

Table 2
Behaviors significantly related to sex, age, degree, and licensure status ($p < .001$)

Item	Direction	χ^2	*df*
1. Becoming social friends with a former client.	Unlicensed more likely	18.7	4
2. Charging a client no fee for therapy.	Unlicensed more likely	41.0	4
3. Providing therapy to one of your friends.	Unlicensed more likely	50.0	4
8. Using a computerized test interpretation service	Male more likely	19.6	4
9. Hugging a client.	Female more likely	43.2	4
10. Terminating therapy if a client cannot pay.	Licensed more likely	24.3	4
13. Having clients take tests (e.g., MMPI) at home.	Male more likely	22.5	4
14. Altering a diagnosis to meet insurance criteria.	Licensed more likely	42.3	4
17. Using collection agency to collect late fees.	Licensed more likely	24.6	4
24. Accepting only male or female clients.	No advanced degree more likely	28.3	8
26. Raising the fee during the course of therapy.	Licensed more likely	32.2	4
29. Allowing a client to run up a large unpaid bill.	Licensed more likely	28.6	4
33. Inviting clients to a party or social event.	Unlicensed more likely	32.3	4
42. Telling clients of your disappointment in them.	Male more likely	18.1	3
44. Providing therapy to your student or supervisee.	No advanced degree more likely	26.1	8
51. Providing therapy to one of your employees.	No advanced degree more likely Unlicensed more likely	39.1 40.3	8 4
52. Having a client address you by your first name.	Younger more likely Masters more likely than doctorate or no graduate degree	49.5 47.8	12 8
53. Sending holiday greeting cards to your clients.	No advanced degree more likely	28.4	8
59. Going to a client's special event (e.g., wedding).	Unlicensed more likely	23.9	4
65. Giving personal advice on radio, television, etc.	Male more likely	26.4	4
66. Being sexually attracted to a client.	Male more likely	70.5	4
75. Engaging in sexual fantasy about a client.	Male more likely	52.7	4
76. Accepting a gift worth less than $5 from a client.	Licensed more likely	26.7	4
79. Charging for missed appointments.	Licensed more likely	39.7	4

out seeing the child first, although 7% reported that they have done so on occasion. Approximately 94% reported never having accepted a client's decision to commit suicide.

For several practices, 90% of the counselors believed them to be unquestionably unethical, and 90% reported never having engaged in them. Among these rare ethics beliefs and behaviors, two involved issues of confidentiality ("Discussing a client by name with friends, and "Disclosing a name of a client to a class you are teaching"), one involved dual relationships ("Borrowing money from a client"), one involved deception ("Signing for hours a supervisee has not earned"), and one involved competency ("Doing therapy while under the influence of alcohol").

Sex Differences

All but one of the sex differences revealed males being more approving of and more likely to engage in the behavior in question. Females appear to be more cautious with boundary maintenance in counseling. They are less approving of bartering for services in lieu of payment, attending a client's special events, and directly soliciting clients. Males appear to be more relaxed about some issues of profes-

Table 3

Beliefs significantly related to sex, age, degree, and licensure status ($p < .001$)

Item	Direction	χ^2	*df*
3. Providing therapy to one of your friends.	Unlicensed more approving	31.7	4
5. Limiting treatment notes to name, date, and fee.	Doctorate or no graduate degree more approving than masters	29.4	8
9. Hugging a client.	Female more approving	24.1	4
11. Accepting services from a client in lieu of fee.	Male more approving	19.3	4
14. Altering a diagnosis to meet insurance criteria.	Licensed more approving	20.0	4
17. Using collection agency to collect late fees.	Licensed more approving	22.6	4
26. Raising the fee during the course of therapy.	Licensed more approving	25.0	4
33. Inviting clients to a party or social event.	Unlicensed more approving	31.4	4
36. Earning a salary which is a % of client fees.	Masters more approving than doctorate or no graduate degree	33.8	8
42. Telling clients of your disappointment in them.	Older more approving	38.7	12
44. Providing therapy to student or supervisee.	Unlicensed more approving	25.4	4
51. Providing therapy to one of your employees.	Unlicensed more approving	39.3	4
52. Having a client address you by your first name.	Masters more approving than doctorate or no graduate degree	28.1	8
	Licensed more approving	18.7	4
55. Engaging in erotic activity with a client.	Older more approving	32.3	9
58. Engaging in sex with a clinical supervisee.	Older more approving	47.4	9
59. Going to a client's special event (e.g., wedding).	Male more approving	20.1	4
61. Going into business with a client.	Older more approving	37.6	12
	Unlicensed more approving	19.8	4
63. Utilizing involuntary hospitalization.	Licensed more approving	26.0	4
66. Being sexually attracted to a client.	Advanced degree more approving	26.8	8
	Licensed more approving	29.9	4
76. Accepting a gift worth less than $5 from client.	Licensed more approving	19.4	4
78. Disrobing in the presence of a client.	Older more approving	31.1	9
79. Charging for missed appointments.	Advanced degree more approving	36.7	8
	Licensed more approving	37.4	4
81. Directly soliciting a person to be a client.	Male more approving	19.5	4
83. Helping a client file a complaint regarding a colleague.	Licensed more approving	38.6	4
85. Not telling a client the limits of confidentiality.	Older more approving	32.9	12

sionalism, more willing to send tests (e.g., MMPI) home with clients (see "Report of the Ethics Committee," 1994), more inclined to use computerized test interpretation services, and more likely to give personal advice on television and radio. Despite females reporting less sexual attraction toward and fantasies about clients, there were no gender differences for sexual contact with clients, and males reported less likelihood and approval of hugging clients than females.

Although some of these differences may be due to gender, per se, others may be due to the different positions that men and women in our sample hold. For example, it seems likely that more men than

women in the sample were ordained, registered, or licensed as ministers. Only 24 respondents listed ordination under "licenses held," and 19 of those were males. However, many more respondents may have been ordained ministers who did not list their ordination as a license, and since many denominations do not ordain women, most ministers in our sample were probably male. Ministers are frequently faced with counseling relationships with blurred role definitions as they are called upon to help parishioners (see Craig, 1991). Thus, some of the differences reported here as sex differences may actually be due to professional role differences. Similarly, respondents with doctoral degrees were more likely to be men than women ($\chi^2 = 10.2$; $df = 2$; $p < .01$), and doctoral education may put men in a position of using psychological tests more frequently. The sex differences in items related to testing may reflect different professional responsibilities for men and women in the sample.

Age Differences

The only behavioral difference based on age is that younger therapists are more likely than older therapists to have clients address them by first name. A number of age-related differences were seen on the beliefs about whether a behavior is ethical. The most consistent difference is that older therapists in the sample were more approving of some forms of overt sexual behavior. They were more likely to accept as ethical: engaging in erotic activity with a client, having sexual contact with a clinical supervisee, and disrobing in the presence of a client. It is interesting to note that older surveys of psychologists reveal a higher incidence of therapist-client sexual contact (Holroyd & Brodsky, 1977; Pope, Levenson, & Schover, 1979) than newer surveys (Pope et al., 1987). It may be that therapists who are younger and more recently trained have developed greater awareness of the harmful effects of sexual contact with supervisees and clients. However, it is important to remember that older counselors in this survey did not report a greater frequency of sexual contact with clients, but only a more accepting posture toward some items related to sexual contact.

Similarly, older therapists in this sample were more approving of not telling clients the limits of confidentiality. This may also be related to the recency of training and the fast pace of changes in child abuse reporting and duty to protect standards (Brosig & Kalichman, 1992; Jobes & Berman, 1993; VandeCreek & Knapp, 1993).

Education Differences

Those with advanced degrees were more likely than other respondents to approve of sexual attraction toward clients. Graduate education appears to make Christian counselors more approving of sexual attraction toward clients, perhaps because it is a topic of conversation during graduate-level clinical supervision and classroom discussions. For those who believe sexual attraction is an inevitable part of counseling, and that the best way to cope with attraction is to be honest and self-aware, it will be reassuring to know that graduate education helps counselors be more aware and tolerant of feeling sexually attracted toward clients. For those who believe attraction toward clients inevitably leads toward sinful thoughts and actions, these effects of graduate education will cause concern. Survey findings regarding sexual attraction toward clients are presented in more detail elsewhere (see Case, McMinn, & Meek, 1995; McMinn, Meek, & McRay, in press).

Those with no advanced degree are more likely to accept only male or female clients, provide counseling to students or employees, and send holiday greetings to their clients. This may reflect the emphasis on "friendship counseling" that occurs in many lay counseling programs.

Although 300 surveys were sent to each of three groups—those with no advanced degree, those with a masters degree, and those with a doctorate—the response rate for those with no advanced degree was quite low ($n = 71$) when compared with the other two groups ($n = 228$ and 170, respectively). A number of potential respondents returned an uncompleted survey and explained that it did not pertain to their situation because they were lay counselors and not professional counselors. Although the scale was developed for professional psychologists, and some items might not apply to lay counselors, it is disconcerting that some paraprofessional counselors perceive ethical standards to be less applicable to their work than to the work of professional counselors. Although some of the ethical standards which apply to professional counseling relationships may not apply equally well to paraprofessionals, the need for ethical guidance is nonetheless an essential component of all counseling training and practice.

Differences Based on Licensure

Those licensed as counselors, psychologists, or social workers responded differently than unlicensed respondents on several items. The differences can be summarized in three ways. First, unlicensed counselors are not as cautious as licensed counselors in managing the boundaries of the therapeutic relationship. Unlicensed respondents more frequently become friends with former clients, provide therapy to friends, invite clients to social events, provide therapy to an employee, and go to a client's special event. Further, they do not feel as ethically restrained as licensed respondents to monitor these boundaries. They are more approving of providing therapy to a friend, inviting clients to social events, providing therapy to employees and students, and going into business with a client. Although the roles of licensed and unlicensed counselors differ, both types of therapy require some boundary maintenance to be effective. Those involved in paraprofessional training may need to devote more time to considering appropriate social encounters with clients and the possible detrimental effects of multiple relationships. This is not a simple task because many unlicensed caregivers counsel neighbors and parishioners. Rather than suggesting these relationships are always conflictual and ineffective, it makes more sense to first research the effects of paraprofessional therapy when the nature of the relationship is blurred by social interactions. Until such research is reported, unlicensed counselors should be trained to recognize the potentially damaging effects of exploitative dual relationship (Gottleib, 1993).

Second, licensed and unlicensed respondents function with different financial guidelines. Unlicensed counselors are more likely to see clients for no fee and are less likely to terminate therapy if a client cannot pay, use a collection agency to collect late fees, raise the fee during therapy, and charge for missed appointments. Licensed counselors are also more approving of altering an insurance diagnosis for insurance payment. These differences are not surprising because many paraprofessional therapists do not charge a fee for their services. Lay counseling and pastoral counseling often occur as part of a church's service to a community. Because they often do not have the same financial incentives for their work, unlicensed counselors may be more objective and less inclined to self-justification about some behaviors. For example, altering an insurance diagnosis is unethical (Keith-Spiegel & Koocher, 1985), but many whose livelihood depend on fees do not see it as unethical.

Third, some items on which licensed and unlicensed counselors differ do not relate to either boundary maintenance or finances and seem to reflect the licensed professional's confidence that comes with counseling experience. Licensed respondents were more willing to accept a gift costing less than $5 from a client, more approving of clients addressing them by their first name (especially masters level professionals), more approving of using involuntary hospitalization, and more approving of helping a client file an ethics complaint against a counseling colleague.

Conclusion

In general, the results of this survey support the conclusions that Christian counselors are aware of prevailing ethical standards, and that they conform to those standards. However, we have some concern about the low response rate among those with no graduate degree, and believe the heightened tolerance of multiple-role relationships among some unlicensed counselors warrants further investigation.

Unlicensed Christian counselors are often in situations which defy traditional counselor-client roles, and they cannot always turn to professional ethics codes for helpful guidance (see McMinn, McRay, & Meek, 1995). In the absence of helpful standards for multiple-role relationships, Christian counselors are often left to define their own standards. These results suggest that older males who do not have a professional license may be especially vulnerable to taking more liberties in multiple-role relationships.

We suggest three responses for the Christian mental health care communities. First, a code of ethics must be developed with sensitivity both to the diversity of training among Christian counselors and the unique roles faced by Christian counselors. This Christian counselors code, such as the one currently being developed by the AACC, must apply to paraprofessionals as well as professionals, and should be prescriptive for all members of the AACC. This is not meant as a punitive or restorative recommendation—our research indicates Christian counselors are doing as well as other mental health therapists. Rather, it is a response to the apparent perception that professional ethical standards do not apply to some Christian counselors and the lack of

perceived regulatory resources reported by some respondents (McMinn & Meek, in press).

Second, those involved in paraprofessional training of Christian lay counselors need to carefully address the ethical implications of counselors' choices and actions. Paraprofessional counselors need to understand the treatment relationship as an important ingredient to effective outcome, and monitor the boundaries of the relationship closely. Related to this, self-awareness is an essential skill for ethical practice. It is difficult to know if some counselors' disapproval of sexual attraction toward clients reflects a lack of self-awareness or a careful monitoring of treatment relationships. These findings suggest that graduate education makes counselors more approving of sexual attraction toward clients, though still not as approving as psychologists (Pope et al., 1987) or counselors (Gibson & Pope, 1993) selected without regard to religious values.

Third, this survey raises additional questions for subsequent research. What are the typical boundaries for pastoral and lay counseling situations? Do blurred, non-exploitative boundaries predict poorer treatment outcome than the traditional distance of a professional counseling relationship? What are the long-term effects of disallowing or denying sexual attraction for clients, and what other self-management techniques do Christian counselors use to build self-awareness and keep relationships appropriate?

The popularity of Christian counseling is seen in the rapid growth of the AACC and the burgeoning lay counseling movement (Tan, 1991). The supporting structures required to keep this movement effective and ethical will need to be rapidly, yet carefully, constructed in the years ahead.

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