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Client Views on Confidentiality

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CLIENT VIEWS ON CONFIDENTIALITY

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This Dissertation, submitted by Stephan Podrygula in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota is hereby approved by the Faculty Advisory Committee under whom the work has been done.

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Signature Stephan Podrygula

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ABSTRACT

This study is part of the growing interest in ethical issues in clinical practice. Confidentiality is of particular concern, being regarded by many mental health professionals as a prerequisite for successful treatment. However, conflicts of interest inevitably arise and confidentiality must be weighed against other values. How to deal with these dilemmas has been a matter of considerable debate among professionals; interestingly, the views of clients on these issues have rarely been investigated.

The purpose of the study was to explore the attitudes and expectations of human service/mental health center clients regarding confidentiality. A 36 item scale, consisting primarily of 20 Likert format items, was carefully developed to assess these views, particularly the circumstances under which confidentiality should be broken. It proved highly reliable and had a distinct factor structure. The questionnaire was administered as part of routine intake procedures at 7 North Dakota human service centers; 465 clients responded.

The major finding was that clients are very concerned about confidentiality and value it highly. Although three quarters expressed a preference for absolute confidentiality, they were willing to have it broken in a few circumstances, primarily when the safety of third parties was involved. For example, they felt child abuse should be reported and threatened third parties protected. On the other hand,

they disapproved of some routine professional practices, such as sending personally identifiable data on clients to central registries. To these clients, confidentiality was not an absolute, but was situational and relative to a given context.

Clients very much wanted to be informed about any limits on confidentiality that might exist. While they generally expected confidentiality, they also reported having been in a significant number of situations where it was broken; perhaps as a result, they often hesitated to enter treatment. Their views were compared with those of professionals and nonprofessionals in previous studies. Suggestions were offered for further work, to help actualize ethics in theory, research, and practice.

CHAPTER I

INTRODUCTION

Ethics is a perennial human concern. Ever since people have existed as sentient beings they have faced questions of morality. Philosophy and theology have dealt with standards of conduct from the earliest times. Ethical concerns have been expressed in more pragmatic ways, such as in terms of codes of professional ethics which are as old as professions themselves. Medicine, for example, has had the Hippocratic Oath to guide physicians in their dealings with patients for over 2,000 years. Psychology, early in its development as a profession, created a formal code of ethics which has been kept current since (American Psychological Association, 1981). Psychotherapy, which in some ways can be dated to the start of Freud's psychoanalytic work in the late 19th century, also has had ethical concerns since its beginnings. Freud, for instance, carefully delineated the proper relationship between therapist and client and proscribed some behavior (such as normal social contact between the two) while mandating other (such as complete candor on the part of the patient and strict neutrality on the part of the analyst). Even as a science, psychology is not value free; as a profession, ethical issues are at its core.

A very important ethical issue is that of client rights, which are of concern to society, mental health professionals, and clients

themselves. American society, particularly in terms of its legal and political systems, has a basic commitment to the preservation and enhancement of the rights of its citizens. Mental health professionals (clinical psychologists, psychiatrists, clinical social workers, etc.) have a particular interest in the rights of their clients because of the humanitarian nature of their discipline and its concern with furthering personal responsibility, development, and autonomy. Clients, of course, have the most immediate and personal interest in their own rights. Their concern is particularly fitting because of the history of widespread violations of rights in the past and their own particular vulnerability.

Within recent years, psychologists and other mental health professionals have been paying increasing attention to the area of client or patient rights. The seminal work of Thomas Szasz (1961, 1966, 1967a, 1967b, 1968a, 1968b, 1970a, 1970b) sparked interest in these issues, generated a great deal of debate, and ultimately led to significant changes in outlook and practice. The initial focus of the patient rights movement was on the rights of inpatients, as they were perceived to be at greatest risk of having their rights violated through involuntary commitment, lack of adequate care, and coercive treatment procedures, among other factors (Ginsberg, 1974). However, as the movement progressed, the rights of outpatients received more attention, as did the ethical issues related to the predominant mode of outpatient treatment--psychotherapy.

Confidentiality, privilege, and privacy, issues closely associated with outpatient rights, have become a particular focus of interest

(Gutheil & Appelbaum, 1982; Noll & Rosen, 1982; Shah, 1969, 1970a, 1970b; Slovenko & Usdin, 1963, 1966; Van Hoose & Kottler, 1977; Wilson, S.J., 1978). For example, both the American Psychiatric Association (1970, 1972, 1973, 1979) and the American Psychological Association (1975, 1981) have taken formal positions emphasizing the importance of confidentiality and have developed ethical standards to guide clinical practice. A variety of opinions, many of them divergent, have been expressed as to how these principles should be actualized.

Although "concerns about confidentiality are as old as time" (Jackson, 1974, p. 39), there has been relatively little empirical investigation of this particular topic or ethical issues in general (Aldrich, 1977). Recently, there have been calls for "greater exploration of the philosophical foundations of therapeutic practice and the ethical assumptions on which psychotherapy is predicated" (Karasu, 1980, p. 1511). Ethical behavior, like any other behavior, can be studied objectively (American Psychological Association, Task Force on Privacy and Confidentiality, 1977). Task forces on confidentiality from both the American Psychological Association and the American Psychiatric Association (American Psychiatric Association, Task Force on Confidentiality as it Relates to Third Parties, 1975) along with a number of individual observers ("In the Service of the State," 1978; Meyer & Willage, 1980; Woods, 1977/1978) have stressed the desirability of more research.

Clinical experience provides further rationale for study of this area. Clients do seem to be concerned about it, for example often asking about confidentiality prior to bringing up a particularly

sensitive topic (which is frequently relevant to their problems). Lack of confidentiality can harm a therapeutic relationship or even prevent one from starting. For example, military personnel frequently avoid treatment provided by the military due to a lack of confidentiality and prefer civilian care even though they must pay for such services themselves (Barr & Zunin, 1973; Daniels, 1969; Dubey, 1967; Ruben, 1973; Schwartz, 1971; Ungerleider, 1963; Wilfe, 1976). Trust seems very important for therapy to succeed; trust may be difficult to develop without confidentiality. In certain environments, such as rural areas, privacy and confidentiality may be particularly difficult to maintain (Jeffrey & Reeve, 1978).

If the behavioral sciences are to continue to advance, they must use their methods to study themselves, for example, to gain greater understanding of the factors related to the delivery of mental health services such as psychotherapy. Confidentiality is a crucial issue here, particularly in view of the widespread agreement that it is a prerequisite for successful and ethical treatment (Group for the Advancement of Psychiatry, 1960), and the growing concern with technological (Curran, Laska, Kaplan, & Bank, 1973; Laska & Bank, 1975; Miller, A.R., 1975) and administrative (Bersoff, 1976; Fleming & Maximov, 1974; Plaut, 1974) threats to privacy. If, as Siegel (1979, p. 253) maintains, "privacy and confidentiality are concepts whose time has come," then attitudes and practices related to them merit considerable attention and scientific investigation.

CHAPTER II

LITERATURE REVIEW

The purpose of this chapter is to review the relevant literature on confidentiality as it applies to outpatient treatment, particularly in terms of psychotherapy. The first section provides a background for the area. It defines terms, places the topic within a broader context of concern about ethical issues, identifies current trends, and documents the stress that has been placed on confidentiality. The second section reviews some pragmatic issues: threats to confidentiality, means of protecting client rights, record keeping and other related areas, and agency practices. The third section discusses theoretical issues such as the divergent views on confidentiality, seemingly inevitable conflicts of values, and underlying theories (such as contractual psychiatry and informed consent). The fourth section reviews the empirical literature on confidentiality with a focus on the attitudes and expectations of professionals, nonprofessionals, and actual clients. The final section presents the rationale for the study, states the problem, and outlines the experimental hypotheses.

Background

Confidentiality refers to the ethical obligation a professional has to keep information about a client secret and not release it without proper authorization. Typically, confidential or private information

is not divulged without the fully informed consent of the client. The definition itself presages the difficulties inherent in this concept. The crux of the matter is what constitutes authorized disclosure, and it is this issue that is explored in this study (i.e., what circumstances clients feel justify release of normally secret information without their consent).

The notion of confidentiality, which "relates to matters of professional ethics" (Shah, 1969, p. 57), needs to be differentiated from the related concepts of privilege or privileged communications, and privacy (Shah, 1969, 1970a, 1970b). Privilege "refers to the legal right which exists by statute and which protects the client from having his confidences revealed publicly from the witness stand during legal proceedings without his permission (sic)" (Shah, 1969, p. 57). Privilege is a legal concept with an extensive literature (Bellamy, 1977; Boyd & Heinsen, 1971; De Kraai & Sales, 1982; DeWitt, 1958; Diamond & Weihofen, 1953; Foster, H. H., 1976; Foster, L. M., 1976; Hollender, 1965; Joling, 1974; Kuhlmann, 1968; Perr 1973, 1982; Sadoff, 1974; Slovenko, 1973, 1975, 1976; Slovenko & Usdin, 1963, 1966; Stern, 1959; Tiemann, 1964; Weinberg, 1967); unfortunately, hopes for its usefulness in protecting confidentiality (Goldstein & Katz, 1962) have turned out to be "misguided" (Slovenko, 1974, p. 649).

Of the three, the overarching concept is privacy, which may be defined as the right to be left alone, or "the claim of individuals . . . to determine for themselves when, how, and to what extent information about them is communicated" (Westin, 1968, p. 7). This basic right of all citizens, not of outpatients alone, has been described as "a

fundamental part of our spiritual heritage of freedom" (Ervin, 1974, p. 34). It is being increasingly publicized (Long, 1967; "Private lives," 1979; Westin, 1968) yet progressively threatened (Miller, A. R., 1971, 1975; Neier, 1975; Westin, 1972, 1976). It is of particular concern in medicine (Britton, 1975; Cass & Curran, 1965) and psychotherapy (Miller, A. R., 1975; Noll, 1974, 1976, 1977, 1981; Noll & Hanlon, 1976; Noll & Rosen, 1982; Noll, Robitscher, & Wolpert, 1977) because of the sensitivity of the data involved and the potential of harm in its release or misuse. Indeed, Supreme Court Justice William O. Douglas stated "the right of privacy has no more conspicuous place than in the physician-patient relationship unless it be in the priest-penitant relationship" (Doe v. Bolton, 1973, p. 219).

Interest in patient rights can be viewed as part of the broader concern with ethical issues in the understanding (Halleck, 1971; Kittrie, 1973; Szasz, 1961, 1966, 1968a, 1968b, 1970a, 1970b; Torrey, 1974) and amelioration of behavior disorders or emotional problems (Foster, H. H., 1975; Golann, 1969; Krasner, 1976; Little & Strecker, 1956; Redlich & Mollica, 1976; Shore & Golann, 1973; Slovenko, 1973; Straker, 1975; Tancredi & Slaby, 1977; Van Hoose & Kottler, 1977). For example, emphasis has recently been placed on the values inherent in psychotherapy (Hare-Mustin, Marecek, Kaplan, & Liss-Levinson, 1979; Watson, G., 1958) and the conflicting loyalties of therapists (Freedman, 1978; Hollender, 1960; "In the service of the state," 1978; Noll, 1976; Szasz, 1967a, 1967b, 1968a). One value that is strongly held is the importance of confidentiality in the therapeutic process (Noll, 1974; Spingarn, 1975): "There is wide agreement that confidentiality is

the sine qua non for successful psychiatric treatment" (Group for the Advancement of Psychiatry, 1960, p. 92).

That this interest has grown in recent years can be seen in the steadily increasing number of books published on topics such as legal issues in mental health (Barton & Sanborn, 1978; Gutheil & Appelbaum, 1982; Halleck, 1979, 1980; Hofling, 1981; Lipsitt & Sales, 1980; Rosner, 1982; Schwitzgebel & Schwitzgebel, 1980; Wexler, 1981), malpractice and its prevention (Cohen, 1979; Furrow, 1980; Schutz, 1982; Simon, 1982), the negative aspects of psychiatry (Robitscher, 1980), ethics and values in psychotherapy (Bloch & Chodoff, 1981; Levine, M., 1972; Levy, 1976; Rosenbaum, 1982), and the preservation of client rights (Hannah, Christian, & Clark, 1981). Confidentiality is a relevant issue in all of these areas, for example, in terms of the legal liability a therapist may face for breaking confidentiality (Eger, 1976; Pope, Simpson, & Weiner, 1978; "Roe v. Doe," 1975) yet the pressures on him or her to do so (Annas, 1976; Freedman, 1979; Rappaport, 1977; Robitscher, 1980; Roth & Meisel, 1977; Ruben & Ruben, 1972; Weisstub, 1977).

Within the area of confidentiality itself, current trends include somewhat of a withdrawal from the abstract positions articulated earlier and more of a concern with pragmatic issues (Blomquist, 1977; Everstine, Everstine, Heyman, True, Frey, Johnson, & Seiden, 1980; Wiens, Note 7; Wright, 1981a), such as the need to inform clients of the real limits on confidentiality that exist (Freedman, 1977; Muehleman & Kimmons, 1981; Noll, 1981; Wright, 1981b). Ways of safeguarding confidentiality (Morrison, Federico, & Rosenthal, 1975; National Institute of Mental

Health, 1981; Robinson & Popiel, Note 5) and helping professionals make more sound ethical decisions (Tymchuk, Drapkin, Major-Kingsley, Ackerman, Coffman,& Baum, 1982) have been presented. In general, empirical research is increasing on this (Bloom & Asher, 1982) and related topics (Lipsitt & Sales, 1980).

Confidentiality continues to be regarded as a very important aspect of psychotherapeutic practice (Goldstein & Katz, 1962), for example, it is a focus of interest of professional organizations of psychiatrists (American Psychiatric Association, 1973, 1979), psychologists (American Psychological Association, 1977; American Psychological Association, Committee on Professional Standards, 1981a, 1982), and social workers (Wilson, S. J., 1978). It has been variously described as the "cornerstone" (Moore-Kirkland & Irey, 1981), "keystone" (Barr & Zunin, 1973), and "touchstone" (Renshaw, 1974) of an effective psychotherapeutic relationship. However, it is important to note that there are dissenting positions on its value or usefulness (Berger, 1978; Davidson, 1959; Feldman, M. J., 1967; MacLennan & Felsenfeld, 1968: Miller, A. R., 1971; Moore-Kirkland & Irey, 1981; Olshansky, Grob, & Malamud, 1958).

Why is confidentiality felt to be so important? The responses, which will be presented in detail later on, basically can be grouped into two categories, the moral or theoretical, and the pragmatic. The first position is that clients are entitled to confidentiality as a matter of right and ethics. The second position is that there are specific adverse consequences (for the client, the therapeutic relationship, and even society itself) in the absence of confidentiality, which

justify its existence. Arguments of the first type are moral ones, having to do with matters of value, and as such cannot be evaluated on the basis of empirical evidence. Arguments of the second type, however, can be empirically evaluated; even taken by themselves, they seem persuasive.

From the pragmatic point of view, much of the concern about confidentiality stems from the fact that emotional disturbance and treatment for it remain highly stigmatizing (Freedman, 1974; Melchiode & Jacobson, 1976; Rosen, C. E., Cowan, C., & Grandison, R. J., 1982; Silver, Nadelson, Joseph, Covi, Jones, & Ruff, 1979; Slaby, Lieb, & Tancredi, 1981; Wiens, Note 7). Even the mere fact that an individual has sought help can damage employment (Cowing, 1974; Farina & Felner, 1973; Gallivan, 1963; Grossman, 1971; Hayden, 1976; Hitchings, 1976; Kaercher, 1981; Menninger & English, 1965; Olshansky, et al., 1958; "Private lives," 1979; Schwartz, 1971; Slovenko, 1977; Ungerleider, 1963; Weinstock & Haft, 1974; Whatley, 1959) and educational opportunities (Callahan & Gaylin, 1974; Errera, 1968; Noland, 1971; "The oath of secrecy," 1967). It is very ironic to note that mental health professionals themselves fear damage to their careers if their confidentiality is breached (American Psychiatric Association, Task Force to Study Arbitrary Discrimination, 1978; Larson, 1981; Terr, 1977).

There is growing empirical evidence that lack of confidentiality can have adverse consequences on the therapeutic process itself (Meyer & Willage, 1980; Singer, 1978; Wise, 1978; Woods, 1977/1978; Woods & McNamera, 1980). Potential clients may delay coming in for treatment, perhaps exacerbating their problems, or even avoid it entirely

("Functional overlap," 1962; Meyer & Smith, 1977: Rosen, 1976a, 1978a, 1978b; Stevens & Shearer, Note 6). Unjustified breaches of confidentiality can be particularly devastating to both client and therapist (McCann & Cutler, 1979; Wright, 1981b). If avoidance of personal suffering is an important societal goal, if therapeutic intervention can ameliorate distress, and if confidentiality is essential for individuals to gain the full benefit from treatment, then lack of confidentiality may have significant negative ramifications for individuals and society.

Pragmatic Issues

There have been numerous discussions of confidentiality, privacy, and privilege, particularly in regard to psychotherapy (e.g., Allen, 1973; De Marneffe, 1976; Foster, H. H., 1976; Grossman, 1977; Ladd, 1971; Mariner, 1967; Reynolds, 1976, 1977; Schuchman, 1975; U.S. Congress, 1974; Westin, 1968). Many have argued that confidentiality is essential (Dubey, 1974; Lifschutz, 1971; Slawson, 1969; Stern, H. R., 1959; Teichner, 1975; Waelder, 1962), some that it should be absolute (Hollender, 1965; Siegel, 1976; X, 1965). Concern has been voiced about the intrusion of third parties into treatment, with attendant loss of privacy (Chodoff, 1972, 1978; Shwed, Kuvin, & Baliga, 1979; Spingarn, 1975; Stone 1976b; Wohl, 1974). The insurance industry has come under sharp criticism for alleged violations of privacy ("Capitol Hill," 1976; Entmacher, 1975; Grossman, 1971; Kaercher, 1981; Lipson, 1975, 1976, Notes 2 & 3; Nye, 1979; U.S. Congress, 1975; "Widespread theft," 1976), as have employers (Hayden, 1976; Kaercher, 1981), and even the government (Beigler, 1981a). Technological threats to privacy have been

viewed with particular alarm (Godwin & Bode, 1971; Kelley & Weston, 1974a, 1974b, 1975; Noble, 1971; "Personal privacy," 1977; Westin, 1968, 1972, 1974, 1976).

Confidentiality issues have been raised in the areas of community mental health (Jeffrey & Reeve, 1978; Joseph & Peele, 1975; Kelley & Weston, 1974a; Lewis, 1967; Noll & Hanlon, 1976; Pattison, Hackenberg, Wayne, & Wood, 1976), marital and family therapy (Feldman, M. J., 1967; Hines & Hare-Mustin, 1978; Margolin, 1982), treatment of children and adolescents (Hofmann, 1975; Holder, 1977; Malmquist, 1965; Mc Guire, 1974; Miller, D., 1977; Perr, 1976; Rosen, A. C., Rekers, G. A., & Bentler, P. M., 1978; Weinapple & Perr, 1981; Wilson, J. P., 1978), group therapy (Foster, L. M., 1975; Gazda, Duncan, & Sisson, 1971; Grosser & Paul, 1964; Slovenko, 1977; Tauber, 1973), psychological evaluation (Crisci, 1975/1975), court ordered treatment (Huffman, 1972), educational efforts to prevent drug abuse (Kinsella, 1971), taping of clients (Berger, 1978; Mason, 1969), psychiatric care in the military (Barr & Zunin, 1973; Bey & Chapman, 1974; Daniels, 1969), and psychoanalysis (Kairys, 1964; Szasz, 1958, 1960; Teichner, 1975; Waelder, 1962; Watson, A. S., 1972). The consumer movement has had an impact (Hollander 1976; Strupp, 1975), for example in terms of the issue of clients' access to their own records (Brodsky, 1972; Entmacher & Gutman, 1973; Kaiser, 1975; Strassburger, 1975; Westin, 1977). Failure to meet client needs can lead to an erosion of trust (Jellinek, 1976) with a subsequent decrease in the effectiveness of treatment.

Even the routine practices of agencies and professionals have come under scrutiny in terms of their possible impact on client rights (Abel & Johnson, 1978; McNamera & Starr, 1973; Warman, 1963). Rosen's studies on patient compliance (1976a, 1976b, 1977, 1978a, 1978b) with agency intake procedures indicate that subtle contextual factors can have a dramatic effect on client behavior. Specifically, she found that simply informing clients of their rights (not to have their name sent to a central state registry) resulted in those rights being asserted much more frequently. In an equally provocative article, Levenson and Pope (1981) point out that agency intake procedures can have a major effect on clients but are rarely subjected to careful study, perhaps out of a fear of what professionals might find. There also appears to be a double standard, based on economic factors, as far as quality of care and patient rights are concerned: Clients at public treatment facilities may fare less well than those who go to private practitioners (Bernstein, A. H., 1973; Felch, 1976; Feldman, S., 1973; Halleck, 1981; Leifer, 1969; Plaus, 1973).

Increasing attention is being paid to the records kept on clients. Riscalla (1974), for instance, stresses the need for high standards in record keeping; this is very desirable because electronic data systems can spread inaccurate information very easily (Miller, A. R., 1975) and cause harm to clients. Some (e.g., Jackson, 1975; Weisstub, 1977) advocate keeping dual records so sensitive information (e.g., therapists' personal speculations and hypotheses) can be kept separate from, and remain more private than, routine data (such as length of treatment).

If confidential information is to be disclosed only with the

client's fully informed consent (Miller, A. R., 1975; Noll, 1976; Plaus, 1973; Schuchman, 1975) then it is logical that clients have full access to their own records so that they know exactly what is to be disclosed (Cass & Curran, 1965; Miller, A. R., 1975). There seems to be a trend toward more open records (Brant, Garinger, & Brant, 1976; Felch, 1976; Kaiser, 1975; Strassburger, 1975), both for ethical and therapeutic reasons (Brodsky, 1972; Fischer, 1972; Houghkirk, 1977). Increased client access to records has been proposed as one way of enhancing confidentiality (Roth, Wolford, & Meisel, 1980) and protecting rights (Lister, Baker, & Milhous, 1975). This can sensitize all parties to the value of relevant and accurate information (Gutheil, 1980). Generally, the results have been positive (Altman, Reich, Kelly, & Rogers, 1980; Golodetz, Ruess, & Milhous, 1976; "How to reduce," 1975).

As systems external to the client-therapist dyad become involved, threats to confidentiality increase (Karasu, 1980; Reynolds, 1976). Therapy within an institution by itself raises questions as to the allegiance of the therapist (Callahan & Gaylin, 1974; Powledge, 1977; Riscalla, 1972), and the client's interests, such as privacy, may become secondary. For example, administrative requirements may result in the keeping of needlessly thorough records (Ladd, 1971), the disclosure of which may harm the client. Whatever is written or recorded must be presumed vulnerable to exposure (Lewis, 1967). Routine procedures such as case staffings, supervision (Lowenthal, 1974), and even typing and filing can result in damaging disclosures (Grossman, 1971).

When third parties outside the agency become involved (Mariner, 1971), the situation deteriorates rapidly. Higher administrative levels frequently request information about clients (Noll & Hanlon, 1976), as do funding sources (Reynolds, 1976). Some of these intrusions themselves serve useful purposes, such as assessing quality of services offered (Dorsey, 1974), gathering data for research to improve treatment (Rada & Jones, 1975; Martin, 1977; Robins, 1977), and increasing accountability (Gosfield, 1975). When third parties, such as insurance companies, pay for therapy, they expect, and usually receive, information in return (Noll, 1974, 1976). While third party payment may make mental health services available to individuals who otherwise could not have afforded them, it results in some loss of privacy. It should be noted that insurance companies have been accused of participating in and/or condoning the use of illegal means to obtain clinical records ("Capitol Hill," 1976; "Widespread theft," 1976).

Federal government access to client records poses major risks, but often serves vital national interests, such as protecting the safety of nuclear weapons (Dubey, 1967) and safeguarding classified information (Solomon, Kleeman, & Curran, 1971). It is, of course, extremely ironic that one form of secrecy be broken to safeguard another, but this is a matter of conflicting values and competing ethical and political views. Authorized access by government law enforcement and intelligence agencies is troublesome enough without considering the possibility of illegal actions, which pose the gravest risks. It is not inconceivable that mental health records could be used to coerce, intimidate, or blackmail dissidents or simply

individuals who espouse unpopular beliefs or belong to certain social, ethnic, or racial groups. To appreciate the dangers, one has only to look back upon the Watergate period when the "plumbers" burglarized the office of Dr. Lewis Fielding, Daniel Ellsberg's psychiatrist, in an attempt to find information to discredit Ellsberg, a vociferous opponent of the then current presidential administration (Beigler, 1981b).

Technological advances in the collection, storage, and dissemination of data (Springer, 1971) are thought to pose a special risk to privacy and confidentiality (Bennett & Gruenberg, 1970; Gobert, 1976; Miller, A. R., 1971, 1975; Westin, 1972, 1974). New computer technology makes possible, and even encourages, the collection of increasing amounts of data on each person in society (Laska & Bank, 1975). More information is being obtained, stored, and shared, often with very little in the way of safeguards (Chodoff, 1972; Grossman, 1977; Noll & Hanlon, 1976; Plaut, 1974). "The basic moral issues of confidentiality are the same for automated as for non-automated records, but additional and menacing dangers arise from the increased efficiency of the computer" (Kedward, Eastwood, & Furlong, 1973, p. 135). Technological advancement has been so great in quantity as to constitute a qualitative change in progress and, consequently, in risk. Insurance company data banks contain sensitive medical and psychological information (Entmacher, 1975; Entmacher & Gutman, 1973; Grossman, 1971; Levine, C., 1977; MacDonald, 1974; Noble, 1971; Stern, L. C., 1974; U. S. Congress, 1975; Westin, 1976; Westin & Isbell, 1977) on tens of millions of people; if national

health insurance were to be adopted, records would be kept on nearly every citizen. Such concentration of information, and thus power, would constitute a major threat to the rights of outpatients and to the rights of each citizen in a democratic society.

One might expect the law to be a powerful safeguard for confidentiality, but in many cases it threatens rather than protects (Epstein, Steingarten, Weinstein, & Nashel, 1977; Robitscher, 1975). It is a common complaint of mental health workers that the law does not provide adequate protection for the information clients reveal (Bernstein, B. E., 1977; Grossman, 1977; Meyer & Smith, 1977; Noll, 1976; Reynolds, 1976), and even forces its disclosure in certain cases, such as suspected child abuse or threatened harm to another person (Bersoff, 1976; Curran, 1975; Gurevitz, 1977). Although therapists often campaign for stricter privilege laws (Foster, L. M., 1974, 1976), their usefulness is questionable because of the many exceptions they typically contain. Nevertheless, the law could provide protection (Bennett, 1974; Blume, 1977; Scott, 1977), rather than serve as a threat (Ladd, 1971). The failure to regulate the private, often commercial, collection of data (such as by credit bureaus and insurance companies) is a major shortcoming.

On the positive side, numerous ways of protecting confidentiality have been suggested: educational efforts to raise the consciousness of therapists about ethics (Wiskoff, 1960), broadened privilege statutes (Meyer & Smith, 1977), tighter administrative rules (Baldwin, Leff, & Wing, 1976; Bennett, 1974; Blume, 1977), improved physical security of data systems (MacDonald, 1974), more sophisticated

computer systems (Curran, Laska, Kaplan, & Bank, 1973; Ford, 1976), less recording of sensitive information (Miller, A. R., 1975), better laws (American Psychiatric Association, 1979; Beigler, 1979; Blume, 1977; Melton, 1981; Nye, 1979; Shlensky, 1977), noncompliance with requests for information (Closson, Hall, & Mason, 1970; Noll, 1974; Sadoff, 1979), creation of commissions to study these matters (Schuchman, 1975), greater activism on the part of therapists (Mariner, 1967), collective action to resist oppressive regulations (Bennett, 1974), and simple procedural safeguards (Rosen, 1976a, 1977).

The increased amount of research on professionals' ethical decision making, attitudes (Bass, 1971/1972; Bass & Dole, 1977; Brown, 1977/1978; Fuller, 1972a, 1972b; Gazda, 1971; Tymchuk et al., 1982), and training practices (De Palma & Drake, 1956; Jorgensen & Weigel, 1973) is certainly positive. Hopefully, the results of these studies can lead to more ethical behavior on the part of therapists; for example, training efforts (Baldick, 1977; Tymchuk et al., 1982) seem to have positive results. While it is highly questionable whether professional groups can adequately regulate themselves (McCleery, Keelty, Lam, Phillips, & Quirin, 1971; Moore, 1978; Taylor & Torrey, 1972; Zitrin & Klein, 1976), some of their activities can be helpful, such as the formulation and widespread dissemination of codes of conduct (Pattison et al., 1976). Moore (1978, p. 161) observes that "the true functions of an ethics code are sensitization and structuring;" to ask more than this is probably to expect too much. Ideally, a system of checks and balances, or a series of

countervailing forces, would help control professional conduct and insure that it would be ethical. To some extent this is already the case as "malpractice suits, in effect, serve as a legal device for regulating" (Slaby et al., 1981, p. 274) professional behavior.

It is ironic that growing professional concern about confidentiality has paralleled increased threats to confidentiality. The current greater emphasis on accountability, both fiscal and administrative, is a case in point. As funds for human services diminish, accountability and cost containment assume more importance. Unfortunately, these goals may conflict with optimally effective treatment which seems to require a high level of confidentiality. The trend to consolidate various mental health, rehabilitative, and social services under the umbrella of human services (primarily, to achieve greater efficiency) continues. An example of this is the merging of community mental health centers and area social service centers into unified human service centers in the State of North Dakota. While this may be laudable from an administrative viewpoint, it may result in significant problems as far as service delivery is concerned, for example, because of the differing values and theoretical positions of the professionals and agencies involved. Pulsifer (1977), for instance, demonstrated that human service professionals tend to value confidentiality less highly than mental health workers. These differences might make it harder for professionals to work together and for clients to receive quality services in a consistent manner.

Theoretical Issues

Although there is general agreement that confidentiality is an important part of the therapeutic relationship, significant differences of opinion exist as to the degree of confidentiality that is desirable. Some even favor the absolutist position, that no information should ever be released under any circumstances without the consent of the client (Siegel, 1976; Watson, A. S., 1972; X, 1965). Others favor a more permissive stance (Blaine, 1964; Lowenthal, 1974), as generally do the laws in most states (e.g., Illinois, n.d.). Indeed many laws mandate a duty to break confidentiality, particularly in the required reporting of suspected child abuse and the duty to warn prospective victims of threats made by clients, as a result of the Tarasoff case (Tarasoff v. Regents of University of California et al., 1976).

Arguments for confidentiality include the following: privacy is a basic right in the American legal system; it is highly consistent with the values and ethics of the mental health professions; serious harm can result without it (e.g., to a person's vocational, educational, and economic opportunities); both clients and professionals expect it; information represents power (which can be used against a client); it sets a good model for the client (Karasu, 1980); threats to it are real and significant; it helps establish trust, which is important for successful therapy; experts feel it is desirable; respect for client rights is closely related to the quality of a treatment program (Lister, Baker, & Milhous, 1975); and little corrective action is possible once information is released. Even Freud (1913/1959)

alluded to the importance of confidentiality when he commented that a successful analysis depends upon the patient's complete honesty; without confidentiality, it would presumably be very difficult for a client to be fully open. Halleck (1981) raises the question of how a mental health professional would want a family member treated; it is difficult to imagine that many would argue against confidentiality in such circumstances (Gallivan, 1963).

Arguments against confidentiality include the following: privacy can be used to hide shame associated with emotional disturbance, which is countertherapeutic (Berger, 1978); it can interfere in intervention with family systems (Feldman, M. J., 1967); strict adherence to confidentiality may be harmful to characterologically disturbed individuals who act out, hurting themselves and others (MacLennan & Felsenfeld, 1968); it can interfere with efficient treatment of "chronic patients" whose needs call for close coordination of multiple caregivers (Miller, R. D., 1981); secrecy merely perpetuates prejudice against patients (Olshansky et al., 1958); history may have a right to information about prominent persons who are deceased, particularly if details of their lives were covered up when they were still alive (Robitscher, 1968); there may be historical utility in preserving detailed records for use by researchers in the future (Marx, 1975); other social priorities, such as protecting children from physical and emotional abuse, may need to take precedence over the privacy rights of clients involved in such activities; fiscal and administrative accountability are difficult to maintain without easy access to records; confidentiality may be irrelevant when

compared with other needs, such as for high quality treatment programs; the utility of record keeping (e.g., in terms of legal protection for the client, service provider, and agency) may outweigh that of confidentiality, the two sometimes being incompatible; and the safety of persons affected by impaired individuals in sensitive jobs (such as physician, airline pilot, etc.) may require that their employers be informed about the risks that are posed.

Generally, arguments against confidentiality are based upon appeals to competing values and sometimes the added premise that the information a therapist has will somehow be relevant to the furtherance of the alternate objective. This is particularly clear in the case of the duty to warn intended victims, imposed by the Tarasoff decision. It is held that the safety of innocent third parties requires a therapist to breach confidentiality and warn them of the harm that is likely to befall them: public safety is felt to be more important than patient privacy (Knapp & Vandecreek, 1982; Leonard, 1977; Morrow, 1976; Olander, 1978; Wilson, L., 1981). Unfortunately, the imposition of this duty may not recognize the relative inability of therapists to predict dangerousness and the limited value informing the victim may have (Curran, 1975; Daley, 1975; Roth & Meisel, 1977).

Since many of the arguments for confidentiality are based upon fairly traditional models of therapy, such as psychoanalysis or contractual psychiatry (as outlined by Szasz), those who accept other models may reach different conclusions (Begelman, 1973). For example, Moore-Kirkland and Irey (1981) start from a family therapy per-

spective and argue that confidentiality may be somewhat of an outmoded notion when it comes to successfully intervening with dysfunctional families and larger social systems. That the contractual model is of limited value in working with some clients, particularly highly dysfunctional, chronic ones who need a lot more in the way of services (e.g., welfare, partial hospitalization, sheltered living arrangements, etc.) than a solo practitioner can provide, suggests that differing approaches to confidentiality may be desirable with different types of clients and therapeutic situations.

Confidentiality is not a simple matter, conflicting values and interests abound. For example, the right of the individual to achieve economic protection through the purchase of insurance may necessitate the loss of the right of complete privacy, as the insurer requires some access to the client's records to assess risk and justify payment of benefits (Altman, 1981; Lipson, Notes 2 & 3; Stern, 1974; U.S. Congress, 1975). Similarly, management of scarce resources may justify some centralized control and supervision of local agency practices to assure that mental health/human services are being provided in an effective and efficient manner (Cohen, Conwell, Ozarin, & Ochberg, 1974; Haywood, 1976; Liptzin, 1974). Dubey (1967) insightfully discusses the role of the armed forces psychiatrist and points out that divided loyalties produce ethical dilemmas (Powledge, 1977; Riscalla, 1972). Yet he maintains that important social needs must be met, sometimes at the price of individual rights. For example, the security of nuclear weapons, a vital national priority, for obvious reasons, demands that military personnel be evaluated for

emotional stability, a process which infringes on their privacy.

Strict confidentiality may run counter to considerations of public safety (Blanc, LaFontaine, LaPlane, 1966; Lindenthal & Thomas, 1980; "Medical aspects of driver licensing," 1969; Tymchuk et al., 1982; Wise, 1978), training needs (Berger, 1978; Enelow, 1978; Rosenbaum, 1978; Szasz & Nemiroff, 1963), professional publication (Leland, 1978; "Roe v. Doe," 1975), prevention of child abuse and neglect (Muehleman & Kimmons, 1981), submission of accurate insurance claims (Sharfstein, Towery, & Milowe, 1980; Towery & Sharfstein, 1978), maintenance of records necessary for optimal health care (Annas, Glantz, & Katz, 1981; Kedward, Eastwood, & Furlong, 1973; Weed, 1974; Wilczynski, 1981) research (Sawyer & Schechter, 1968), collection of overdue accounts (Faustman, 1982), quality control (Ebert, 1976a, 1976b), protection of therapists against malpractice claims (Gutheil, 1980), and efforts to maintain administrative and fiscal accountability in agency settings (Appleton, Note 1; Rosen, 1976a, 1978a, 1978b).

Regrettably, there is currently no comprehensive theory of patient rights in which confidentiality can find a firm place. While Szasz has been the most influential figure in this area, he has not formulated a systematic theory of outpatient rights. Kittrie (1973), Leifer (1969), and Torrey (1974) have offered significant theoretical insights, and Goldberg (1977) has even formulated a practical contractual theory of psychotherapy. One of the recurrent themes in the literature on patient rights is the double agent role of the therapist and the problems that arise because of this division of loyalties ("In the service of the state," 1978). Although Szasz

originated and developed this notion in his attack on institutional psychiatry (1967a, 1967b, 1968a), it is also applicable to the problem of confidentiality, where the therapist has numerous conflicting pressures and roles (Bersoff, 1975, 1976).

The theory of informed consent (Meisel, Roth, & Lidz, 1977) has been applied to psychotherapy, particularly by Noll (1976; 1981; Noll & Rosen, 1982), in an effort to at least inform clients as to what they are becoming involved in and the risks associated with it (such as loss of privacy and confidentiality). Application of informed consent procedures generally has a positive effect on treatment (Alfidi, 1971; Denney, Williamson, & Penn, 1976; Melton, 1981; Park, Covi, & Uhlenhuth, 1967; Rosenberg, 1973; Singer, 1978). Along with Noll, Dix (1981) has also urged that clients be given a Miranda type warning about the therapist's obligation to break confidentiality in certain circumstances. Clients could also be informed about record keeping and computerized data banks (Beggs-Baker, Nick, Chase, Keller, & Vallbona, 1974; Diamond & Weihofen, 1953), release of information authorizations (Shlensky, 1977), and the lack of confidentiality in court ordered evaluations (Pollack, 1968). Whatever the therapist's theoretical stance, discussion of values issues with clients may be appropriate (Lidz, 1980).

Empirical Research

A comprehensive review of the literature reveals about two dozen empirical studies on confidentiality. The attitudes and expectations of actual clients (Angelo, 1978; Appleton, Note 1;

Garfield & Wolpin, 1963; Lewis & Warman, 1964; Meyer & Willage, 1980; Morrison, Federico, & Rosenthal, 1975; Rosen, 1976a, 1976b; 1977; 1978a; 1978b; Simmons, 1968), nonclients ("Functional overlap," 1962; Melchiode & Jacobson, 1976; Meyer & Willage, 1980; Singer, 1978; Stevens & Shearer, Note 6; Woods, 1977/1978; Woods & McNamera, 1980), and professionals (Appleton, Note 1; "Functional overlap," 1962; Jagim, Wittman, & Noll, 1978; Laves & Cohen, 1973; Lindenthal & Thomas, 1980; Melton, 1981; Muehleman & Kimmons, 1981; Sharfstein et al., 1980; Szasz & Nemiroff, 1963; Tymchuk et al., 1982; Wilson, J. P., 1978; Wise, 1978) have been studied.

Related topics have included therapists' knowledge of relevant legal and professional standards (Jagim et al., 1978; Marsh & Kinnick, 1970; McGuire, 1974; Melton, 1981; Suarez & Balcanoff, 1966; Swoboda, Elwork, Sales, & Levine, 1978); their attitudes (Cole, 1971; Lipson, Note 2; Little & Strecker, 1956; Mykel, 1971; Shore & Golann, 1969; Szasz, 1962; Wiskoff, 1959, 1960) and personal characteristics (Brown, 1977/1978, Cole, 1971; Pulsifer, 1977; Wiskoff, 1960); institutional practices (Curran, 1969; Jagim et al., 1978; Kelley & Weston, 1975; Newman, Note 4; Noland, 1971; Noll & Hanlon, 1976; Rosen, 1976a, 1976b, 1977, 1978a, 1978b); psychoanalytic training (Szasz, 1962); effects of client access to records (Stein, Furedy, Simonton, & Neuffer, 1979); and informed consent to hospitalization (Meisel & Roth, 1976; Olin & Olin, 1975). Unfortunately, there appear to be no empirical data on the adverse consequences of breach of confidentiality, although there is some anecdotal evidence (Errera, 1968; Grossman, 1971; Noll, 1974).

It is disappointing to note that several studies have shown a widespread lack of sophistication on the part of professionals regarding the legal aspects of confidentiality and privilege. College faculty and student personnel workers (Marsh & Kinnick, 1970); psychologists, and other mental health workers in North Dakota (Jagim et al., 1978); Massachusetts psychiatrists (Suarez & Balcanoff, 1966); therapists involved in the treatment of children (Mc Guire, 1974); and a variety of Nebraska mental health workers (Swoboda et al., 1978) all showed relatively little knowledge about and/or limited compliance with laws relating to or impacting on confidentiality.

A large number of professionals express a positive attitude toward confidentiality. For example, Cole (1971) found that psychiatrists were reluctant to exchange information with patients' employers; those practicing privately tended to separate treatment from the work setting (thus implicitly supporting confidentiality) more than those in public employment. This is consistent with Wiskoff's (1960) findings and supports the belief, expressed by Szasz, among others, that contractual psychiatry may be more protective of patient rights. The work of Lipson (Notes 1 & 2) and Sharfstein et al. (1980) shows that psychiatrists distrust insurance companies, fear loss of confidentiality in dealing with them, and even take practical steps to make disclosures less damaging.

Little & Strecker (1956) found significant individual differences in psychiatrists' attitudes, as did Mykal (1971) in her survey of therapy group leaders. Psychologists active in community mental health regard confidentiality as an important problem (Shore & Golann, 1969).

Therapist background variables and personal characteristics have been found related to their attitudes and stated practices (Cole, 1971; Wiskoff, 1959, 1960). Pulsifer's (1977) finding that human services and mental health professionals differ in their conceptions of confidentiality is interesting in view of the tendency to combine varied agencies into unified human service centers.

Although Szasz is usually thought of as a theoretician and advocate rather than a researcher, he was in fact a pioneer in empirical work with his 1962 study of psychoanalytic society members' attitudes toward privacy and the training analysis. That 71% of his American respondents (p. 203) stated that training analysts should communicate with officers of psychoanalytic institutes and societies regarding the progress of their candidates represents a remarkable concession to competing values (e.g., protecting the public by maintaining very high standards in training) by a group widely respected for it strong advocacy of confidentiality. This study raises critical issues such as ethics in the training of psychotherapists and the inherent conflict of values in ethical decision making.

Institutional factors that compromise confidentiality include laws that mandate reporting of suspected child abuse and similar activities (Jagim et al., 1978; Noll, 1976; Swoboda et al., 1978), the common practice of reporting personally identifiable data on clients to central registries (Kelley & Weston, 1975; Noll & Hanlon, 1976), sharing of information on student participation in therapy as part of the college admissions process (Noland, 1971), and agency intake procedures that lead clients to give up their privacy (Rosen,

1976a, 1976b). Despite expressed support for confidentiality (Curran, 1969), institutions and the professionals operating within them often do not meet their stated ethical standards (Newman, Note 4).

Research on confidentiality concerns of nonprofessionals also yields interesting results. Marsh and Kinnick (1970) found that college students tend to assume confidentiality exists where it really does not and that nonprofessionals are more confused about these matters than are mental health professionals. Melchiode and Jacobson (1976) found continued evidence of stigmatization of expatients in employment settings and speculated that employees would be concerned enough about this to pay for treatment expenses themselves, rather than submit insurance claims through their employers. Meyer and Smith (1977) reported that potential therapy group members would prefer not to enter a group without a guaranty of confidentiality, or would reduce their level of disclosure if they did enter such a group. Stevens and Shearer (Note 6) discovered that their college student subjects strongly favored confidentiality but felt it could and should be broken to prevent harm being done to others. It is fairly well established that individuals report they would limit their disclosures in a therapy situation without confidentiality ("Functional overlap," 1962; Lewis & Warman, 1964; Meyer & Smith, 1977).

There have been relatively few studies on the attitudes of actual clients. Angelo (1978) found that mental health agency clients are willing to discuss personal matters for the sake of evaluation of treatment outcomes. Appleton (Note 1, p. 6) discovered that "clients consistently endorse confidentiality" and value it almost as much

as psychologists. Contrary to their expectations, Garfield and Wolpin (1963) found their clients were not particulary concerned about others knowing they were receiving treatment. Both Lewis and Warman (1964) and Simmons (1968), with university counseling center clients as research subjects, found clients relatively unconcerned about release of information regarding themselves to third parties (often without their explicit consent). This appears to reflect considerable faith in the discretion and judgment of their counselors, something which does not appear particularly justified given the data on therapists' limited knowledge of legal issues, and reports of unethical practices.

C. E. Rosen's work (1976a, 1976b, 1977, 1978a, 1978b) is particularly interesting. Out of a sample of 962 new admissions to community mental health centers in Georgia, none (at intake) refused to sign a release form consenting to have personal information about them sent to a central registry (1977, p. 20). In another part of the study, when given the impression that they had no choice but to sign the release form, all signed; when told they did not have to sign, an average of only 30% signed (1971, p. 21). These results suggest unusual compliance upon the part of outpatients to routine agency procedures that reduce privacy (perhaps out of fear of jeopardizing their chance to receive services) and the importance of contextual factors in compliance with requests that may violate rights. Lewis's (1967, p. 949) contention that "the right to privacy is especially invaded by the intake process" seems supported.

Although "there is no research directly assessing whether

privacy or a lack of privacy effects (sic) psychotherapy" (Appleton, Note 1, p. 7), there are several studies which suggest this is indeed the case. Singer (1978) found that confidentiality enhanced the quality of responses to sensitive items in a social survey research proejct; presumably, clients would also be more open in therapy when confidentiality was assured. Woods (1977/1978; Woods & McNamera, 1980) has shown that expectations of confidentiality strongly affect self-disclosure, for example, self-disclosures decrease under experimental conditions of no confidentiality. This is very important because of the common belief that self-disclosure and openness are directly related to therapy outcome. Thus lack of confidentiality would presumably lead to less successful treatment.

In reviewing these issues, Meyer and Willage (1980) concluded that potential clients do not understand the relevant concepts of confidentiality and privilege, accurate information regarding these topics would affect potential clients' decisions about entering treatment, different conditions of confidentiality definitely affect the type of information disclosed, and mental health professionals themselves are not particularly familiar with the applicable concepts and laws. Through their studies and those of others, the link between confidentiality and treatment outcome is being more firmly established in an empirical manner, rather than just a speculative one.

These results suggest that both therapists and clients are uncertain about basic patient rights issues (Lidz, 1980), clients may be unwilling and/or unable to exercise their rights at the time of entry into the mental health care system (if they are even aware of

these rights), confidentiality conditions do affect client actions (such as the decision whether or not to enter treatment and, once in treatment, how much to disclose), clients may be excessively complaint and trusting, contextual factors are important in the preservation or breaking of confidentiality, conflicts of interest occur in many therapeutic situations, and corrective measures may be relatively easy to implement in some cases.

A recurrent theme in the literature is the seemingly inevitable conflict among diverse values and interests. Szasz (1967a, 1967b) has termed this the double agent problem in reference to a therapist's divided loyalties. Jagim et al.'s (1978) study raises this issue particularly clearly: There may be a very serious and potentially damaging conflict of interest if clients expect a high degree of privacy yet therapists do not observe it (choosing, for example, to subordinate their clients' needs to the state's mandate that information be released without the client's consent in certain cases, such as child abuse reporting). "If the therapist does have limits to confidentiality . . . and if clients expect that their communications will remain confidential, the possibility of a conflict of interest is high" (pp. 463-464). Their suggestion that fully informed consent regarding the limits of confidentiality be obtained prior to the start of treatment deserves serious consideration. This is particularly important because it still is unclear what clients expect in the way of confidentiality and because expectations play a significant role in therapy (Goldstein, 1962).

Statement of the Problem

In evaluating the literature, there are many questions that merit further investigation. One of the most intriguing is "what are the expectations of patients" (Daley, 1975, p. 948) regarding confidentiality? To date, much of the focus has been on the views of professionals, rather than on those of clients. It is very possible that the two groups have different attitudes, which may lead to some difficulties. For example, if clients really are indifferent to confidentiality then professionals who favor it may want to reassess their priorities and perhaps put more emphasis on other things that clients value more. On the other hand, it could be argued that if clients don't really care about these issues, then professionals may have an even greater obligation to safeguard clients' rights (since the clients are unwilling and/or unable to assert those rights themselves).

There is significant diversity of opinion as to how clients feel about confidentiality and what they expect. Modlin (1969, p. 15), for example, asserts that "patients really seem somewhat indifferent" about privacy, while Berlin (1973) feels the opposite is true. Morrison, Federico, and Rosenthal (1975) state that group therapy clients take confidentiality seriously. According to Wise (1978), therapists usually feel their clients believe they have absolute confidentiality. Daley (1975, p. 495) states "confidentiality is usually assumed by the patient when he undertakes treatment. Though not usually requested, it is implicit in the relationship." Szasz (Allen, 1973, p. 22) believes that "clients nowadays think they are

buying unqualified privacy" which they, of course, are not receiving. Slovenko (1977, p. 429) reports that "group members assume confidentiality." On the other hand, Daley (1975, p. 951) predicts "lack of absolute confidentiality probably will not deter prospective patients to any great extent." Huffman (1972) feels clients want confidentiality but not necessarily at an absolute level. While Slovenko (1977) claims group members feel confidentiality is important, he also asserts that therapists care more about this than clients. Various reserachers believe lack of confidentiality would have an adverse effect upon clients (Beggs-Baker et al., 1974; Gallivan, 1963; Huffman 1972; Levine, 1972; Rumsey, 1974; Scott, 1977; Weinberg, 1967).

A similar issue has to do with what circumstances, if any, clients feel justify the breaking of confidentiality (Stevens & Shearer, Note 6). Slovenko & Usdin (1963, p. 298) maintain that "the general public, prospective patients and patients in therapy will not lose faith in the psychiatrist as a keeper of secrets when in cases of emergency he acts contrary to strict and absolute confidentiality." However others (Rumsey, 1974; Tiemann, 1964) believe that not only would individual clients lose faith in their therapists but that the public at large would do the same with the profession as a whole. Will what Dimond (Stern, 1959, p. 1078) refers to as "that most essential element of psychotherapeutic practice--the trust and confidence of our patients" be damaged if therapists break confidentiality (even in emergencies)?

The purpose of this study is to explore the views of consumers

of mental health/human services regarding confidentiality. Client views are of intrinsic interest: It is not at all clear what clients think and there is reason to believe that knowing their attitudes would be of practical value. Differences of professional opinion on the matter of what clients expect and prefer exist (Berlin, 1973; Daley, 1975; Modlin, 1969, 1973) and could perhaps be settled. The study could have a definite theoretical value along with a pragmatic one, in terms of highlighting relevant issues in the development of human service centers. The more that is known about clients' needs, the better a position therapists will be in to satisfy them.

The following specific hypotheses have been formulated from the literature, theory, a priori expectations, and previous studies using non-client populations.

Demographic factors affect attitudes toward confidentiality (Goldstein & Katz, 1962; Rosen, 1976a, 1976b, 1978a, 1978b; Singer, 1978; Woods, 1977/1978): Females are more concerned about confidentiality than males (Lindenthal & Thomas, 1980; Woods & McNamera, 1980). Age is inversely correlated with concern about confidentiality (Rosen, 1976a; Singer, 1978). Education is directly correlated with concern about confidentiality (Appleton, Note 1: Rosen, 1978a, 1978b; Singer, 1978). Non-whites are more concerned about confidentiality (Rosen, 1976a). Unmarried or divorced persons are more concerned with confidentiality. Socio-economic status (SES), measured in terms of occupational status, is directly correlated with concern about confidentiality (Appleton, Note 1: Goldstein & Katz, 1962; Ruben & Ruben, 1972).

Treatment factors are related to attitudes toward confidentiality: Clients coming to a center for the first time are more concerned with confidentiality than those who have come previously. Clients with previous treatment are less concerned about confidentiality (Appleton, Note 1). Self-referred clients are the least worried about confidentiality. Clients coming for help voluntarily are much less concerned about confidentiality than those coming involuntarily.

Previous experiences with confidentiality are strongly related to views on this topic (Lindenthal & Thomas, 1980). Few clients report going to a minister/priest/rabbi because of a desire for absolute confidentiality. A significant number of clients report hesitation in getting help because of concerns about confidentiality (Appleton, Note 1). A significant number of clients report having been in a situation where confidentiality has been violated (Appleton, Note 1: McCann & Cutler, 1979; Wright, 1981b). Clients report that a stated lack of confidentiality would keep them from treatment or would limit what they said (Daley, 1975; Freedman, 1974, 1977; Meyer & Smith, 1977; Meyer & Willage, 1980; Ruben & Ruben, 1972; Wise, 1978; Woods, 1977/1978; Woods & McNamera, 1980). Clients whose confidentiality has previously been violated are much more concerned about confidentiality that other clients.

Clients believe confidentiality should be broken under the following circumstances: under court order (Stevens & Shearer, Note 6); for protection of national security; so parents of minors know their children are having problems and are receiving help (Curran, 1969; McGuire, 1974; Melton, 1981; Pulsifer, 1977; Stevens & Shearer,

Note 6; Wilson, J. P., 1978); prevention of suicide (Stevens & Shearer, Note 6); maintenance of fiscal and administrative accountability (Kelley & Weston, 1975; Noll & Hanlon, 1976); preservation of traffic safety, for example, apprehension of individuals driving under the influence of alcohol (Lindenthal & Thomas, 1980; "Medical aspects," 1969); prevention of child abuse and neglect (Jagim et al., 1978; Muehleman & Kimmons, 1981; Swoboda et al., 1978); preservation of law and order, i.e., apprehension of criminals (Lindenthal & Thomas, 1980; Pulsifer, 1977); so employers of persons in sensitive positions are aware of problems their employees have that might interfere with their job and thus affect the welfare of others (Blanc et al., 1966); prevention of homicide or serious harm to another person (Lindenthal & Thomas, 1980; Stevens & Shearer, Note 6; Wise, 1978, Wright, 1981a); consultation with colleagues (Stevens & Shearer, Note 6); none--confidentiality should be absolute (Lewis & Warman, 1964; Stevens & Shearer, Note 6); and preservation of public safety, in general (Lindenthal & Thomas, 1980; Tymchuk et al., 1982 Wise, 1978).

In terms of miscellaneous aspects of confidentiality: Clients very much want access to their own records (Abel & Johnson, 1978; Altman et al., 1980; Felch, 1976; Golodetz et al., 1976; Rosen, 1978a; Roth et al., 1980; Stein et al., 1979; Stevens & Shearer, Note 6). Clients feel confidentiality is relevant and important when they seek help (Appleton, Note 1: Berlin, 1973; Meyer & Smith, 1977; Modlin, 1969, 1973). Clients expect complete confidentiality (Allen, 1973; Appleton, Note 1; Berlin, 1973; Daley, 1975; Garfield & Wolpin,

1963; Jagim et al., 1978; McGuire, 1974; Slovenko & Usdin, 1963; Wise, 1977). Clients are more concerned about inadvertent loss of privacy, such as being seen by a neighbor when they go to a clinic, than deliberate breach of confidentiality by a professional (Jeffrey & Reeve, 1978; Moore-Kirkland & Irey, 1981). Clients agree with professionals that the latter have an obligation to maintain confidentiality (Appleton, Note 1; Jagim et al., 1978). Clients are unconcerned about records maintained on them (Lister et al., 1975). Clients state they are concerned about confidentiality (Jagim et al, 1978; Rosen, 1978a, 1978b, Warman, 1963; Wise, 1978). Clients very much want to be informed about any limitations on confidentiality (Alfidi, 1971; Newman, Note 4; Noll, 1981; Stevens & Shearer, Note 6; Wise, 1978). Client attitudes toward confidentiality are relative to the context and not absolute (Appleton, Note 1; Slovenko & Usdin, 1963; Stevens & Shearer, Note 6). Clients' preferences are incongruent with common practices and limitations on confidentiality (Noll & Hanlon, 1976; Rosen, 1977, 1978a, 1978b; Wise, 1978). Clients would prefer confidentiality when obtaining assistance for personal problems.

CHAPTER III

METHODOLOGY

The purpose of this chapter is to present the methodology used in examining client views on confidentiality. The first part discusses how the research question was conceptualized and operationalized. The second section reviews the development of the items composing the test. The third part describes the development of the test to measure client attitudes. The fourth section describes the research participants or subjects in the study. The fifth portion deals with the experimental procedure, the collection of the data. And the final section describes the analysis of the data.

Conceptualization

The goal of the study is to learn about the views of clients, in outpatient settings, on confidentiality. The initial question is--do clients care about confidentiality? This can be made more precise by asking--to what extent do they care? But in the abstract, this question, and whatever answer might be obtained, does not have much meaning. It needs to be made concrete, particular, and relative to a given context. Reframed in this way, the question becomes--to what extent do clients care about confidentiality in certain circumstances? This way of conceptualizing the problem is supported by the studies

that show ethical issues tend to be multidimensional and decisions relativistic (Bass, 1971/1972; Bass & Dole, 1977; Brown, 1977/1978; Fuller, 1972a, 1972b; Lewis & Warman, 1964; Lindenthal & Thomas, 1980; Little & Strecker, 1956; Simmons, 1968; Stevens & Shearer, Note 6; Tymchuk et al., 1982; Wiskoff, 1959, 1960).

The concept of confidentiality is itself a bit abstract, so it might more easily be understood (particularly by research subjects) by looking at its opposite--release of information without the client's consent. The question thus becomes--to what extent do clients care about release of information, without their consent, in certain circumstances? This can be operationalized by presenting certain situations (as stimuli) and having clients respond on a quantitative scale as to their agreement or disagreement with a hypothetical course of action. The responses to these specific cases should reveal client attitudes regarding what circumstances, if any, justify breach of confidentiality.

Item Development

A comprehensive review of the literature led to the identification of over 1,000 bibliographic items relevant to the topic, only a relatively small proportion of which were identified in two previous bibliographies (Aldrich, 1977; American Psychiatric Museum Association, 1974). These were read and digested; specific questions and issues related to confidentiality were noted and particular emphasis was placed on empirical studies. A master item pool was created, based upon a review of the most pertinent articles and a

subsequent listing of issues, examples, contingencies, and ramifications. This was composed of questions used in about seven dozen previous empirical studies on ethical issues in general, newly developed items (e.g., those particularly relevant to a rural setting), and more general statements (such as expressions of sentiment about confidentiality).

Based upon a thorough review of the literature, analysis of the issues involved, and consideration of the interests of the researcher, it was decided to focus on client attitudes toward disclosure in the following situations: whenever ordered by a court, protection of national security, minors seeking treatment (without parental knowledge or consent), prevention of suicide, maintenance of administrative and fiscal accountability, preservation of traffic safety, prevention of child abuse/neglect, maintenance of law and order, handling impaired employees in sensitive positions, prevention of harm to potential victims of clients assumed to be dangerous, and professional consultation.

The following issues were also of interest: clients' access to their own records, perceived importance of confidentiality to the treatment process, expectations about confidentiality, fear of incidental loss of privacy, perceived obligation of professionals to maintain confidentiality, client preference, informed consent (regarding the limits on confidentiality), use of other caregivers (i.e., minister, priest, rabbi) for complete privacy, subjective hesitation in seeking treatment out of concern regarding confidentiality, reported breaches of confidentiality, perceived effect of

lack of confidentiality upon entry into treatment, and effect of previous violation of confidentiality. It was also felt desirable to look at the influence of demographic factors (sex, age, education, marital status, race, and occupational status) and those related to treatment (previous treatment, referral source, and voluntary or involuntary entry) upon concern about confidentiality.

After specific areas to focus on were determined, items relevant to them were selected from the master pool of about 600 items. The specific items were chosen upon the basis of the following criteria: relevance to the topic, usefulness in testing the hypotheses, overlap with previous studies, the ability to be expressed in an easily understandable manner, and relevance to a human service/mental health center setting. The result of this selection process was a set of 72 highly relevant items, which is presented in Appendix A. Every item in this second pool was rated for inclusion in the questionnaire (using the previous criteria). The 24 highest ranking items (based on the investigator's judgement) were chosen as the final set. Twenty of these could be expressed in the form of a statement for a Likert format scale. The four that could not easily be put into this format were expressed as questions. Several items were also developed to assess demographic variables, factors related to treatment, and previous confidentiality experiences. Finally, an open ended question was included to allow subjects to express their opinions and questions in a free format.

Since the questionnaire was intended to be self-administered, and used in a variety of locations and with a wide range of clients, simplicity in the items was a major consideration. For these reasons, to minimize administration time, and to avoid the introduction of extraneous factors, the items were expressed as simple statements in Likert format rather than developed into vignettes of hypothetical confidentiality related situations, as was the case in some other studies (Lindenthal & Thomas, 1980; Wiskoff, 1959; but not in Fuller, 1972a, or Stevens & Shearer, Note 6). A 5-point scale was chosen because it was felt that one with more points would call for finer discriminations than most clients could reliably make. The scale points were "strongly disagree," "disagree," "neutral," "agree," and "strongly agree." Scoring was set up to be in a pro-confidentiality direction: The highest score, five on a range of one to five, was assigned to the option most associated with confidentiality. When the items were put together, they were presented in a manner to counteract any response set (e.g., to simply agree with all statements): 10 were written so the high scoring end of the scale was "strongly disagree" and 10 were written to be scored in the opposite manner (with a score of five given to the label "strongly agree"). For considerations of space and continuity (e.g., so that highly sensitive items were spread out, placed between fairly innocuous ones, and not located near the ends of the test) items were not arranged in a random or alternating order.

Test Development

Once all of the items were selected, they were combined into a self-administered, four-page, 36-item questionnaire, consisting of 20 Likert format items (on a 5-point scale) meant to directly tap attitudes regarding various aspects of confidentiality. An additional four items (that were not in Likert format) were placed among the 12 questions assessing demographic and other factors. The questionnaire in its final form is presented in Appendix B. Appendix C contains a cover letter to clients that was used at one data collection site.

Most of the development of the test as a whole centered around four stages of pretesting, involving both clients and professionals, which are described in more detail below. The first three were conducted at the North Central Human Service Center in Minot. During the course of this process, improvements in the questionnaire and procedures were made in an ongoing manner to take advantage of what was being learned. The scale was thoroughly pretested for the following reasons: to determine clients' reactions to the instrument, verify the items were understandable, evaluate the possible risk to research participants, check for any problems in administration procedures, and help establish a degree of validity. Although the primary means of demonstrating the questionnaire's validity is by reference to the literature and previous studies, pretesting did help show the scale was measuring confidentiality. For example, 77%, or 14, of the 18 clients responding (at one stage of pretesting) stated the topic was confidentiality or some related

concept (44%, or 8, even using the term "confidentiality"). Similarly, 87%, or 13, of the 15 responding staff (in another phase of pretesting) stated the topic was confidentiality (with 80%, or 12, using that term).

For the three phases that involved actually administering the questionnaire, several items were appended to the scale to assess the subjects' reactions. For example, clients were asked the following questions: whether they had a hard time understanding anything, whether anything about the scale or its administration upset them, whether they would return for help after having taken the questionnaire, and what they thought the study was about.

Clients were also asked to describe how they felt about participating and how they thought others would feel, by checking off any of a large number of descriptive phrases that applied. The most frequently endorsed items were: "the things you asked about are important to me," "I could understand it," "it's good you're doing this kind of research," and "I'm glad you asked me what I think about these things." The least frequently endorsed items (none of which were in fact endorsed) were: "I don't think it's anybody's business what I think about these things," "I couldn't understand it," and "I didn't like it."

A structured interview schedule was also developed to follow up on the responses of clients, support staff, and professionals. The researcher interviewed all human service center staff and 10 of the 25 clients that participated in the (third stage of) pretesting. This allowed the opportunity to more closely assess the reactions

of the participants to the questionnaire and the project as a whole. For example, clients were carefully questioned about whether or not taking part in the study might raise any apprehensions about seeking treatment, how they felt about the study, and what they thought about confidentiality. Reactions of both clients and staff were positive and many significant points were brought up in the discussions.

The first stage of pretesting involved administering the questionnaire to a small, preformed group of highly dysfunctional clients (during a session of a social skills training class). The researcher gave a short ad-lib introduction, distributed the questionnaire, and timed its administration. After all subjects had handed it in, a fairly lengthy group discussion ensued. The participants were very interested in the topic, discussed it freely, and offered some interesting comments both on the questionnaire itself and the topic. For example, they were unanimous in stating confidentiality was a relevant issue for them, all indicated they fully understood the questionnaire, and one even suggested the study be repeated with mental health professionals as subjects. In short, their reaction was very positive. One result recurred throughout the pretesting: most subjects reported an increased awareness of confidentiality, which indicated administration of the instrument had a positive effect. In fact, later on, another client wondered whether the real purpose of the study was to gather data or educate.

The second phase of pretesting consisted of individually giving the questionnaire to 16 human service center staff, 11 pro-

fessionals and 5 support staff, and following up with detailed structured interviews. Professionals from a wide variety of disciplines and backgrounds were represented: addiction counseling, psychiatric nursing, social work, family therapy, vocational rehabilitation counseling, etc. Their response was very positive: for example, 95%, or 15, predicted clients would respond very favorably or favorably to the study, and many indicated their own participation had been an interesting and educational experience. Both they and the clients involved felt the questionnaire was understandable, relevant, unlikely to cause any harm, and addressed the issues it was meant to.

The third stage of pretesting involved actual implementation of the full experimental procedure. Under the very close supervision of the researcher, a pilot study was conducted at one center which involved giving the questionnaire to all newly admitted clients, who met the selection criteria described below, at their first visit. During the course of several weeks, 25 completed questionnaires were returned and 10 clients were carefully interviewed. Again, the reactions to the questionnaire, experimental procedure, and topic were positive. Participation itself was viewed favorably, as seen in one client's comment that "it made me understand you guys a little bit better."

The final stage of pretesting involved obtaining the participation of human service centers in the study and responding to their needs and suggestions. Once it was decided to survey clients in this type of setting, a variety of support materials were devel-

oped to allow data collection at other facilities without direct personal involvement of the researcher. A cover letter to center staff was developed to inform them about the study, for example, its purpose, the procedures involved, and reactions that they might expect from their clients. A copy of one such letter to colleagues is presented in Appendix D. To insure uniformity in data collection procedures, a set of instructions was developed for use by staff who would actually be handing out the questionnaire. A copy of these instructions for one facility is contained in Appendix E. To provide further information to individuals regarding the project, particularly clients who might have questions, a research project information sheet was developed. It is presented as Appendix F. Significant changes were made in these support materials to meet the needs of the participating facilities, as were some changes in the placement and wording of the actual test items.

A copy of the initial questionnaire is not presented because of its very high degree of similarity with the final one, which is given in Appendix B. During the course of pretesting only three significant changes were made in item content: First, an item tapping concern about confidentiality ("I am concerned that what happens here and what a client tells his/her therapist is confidential") was replaced by one tapping preference ("I would like what happens here to remain confidential") since the former proved to be ambiguous. Second, an item asking for the name of the town the client lived in was eliminated because it was felt this might identify clients and cause them to question the anonymity of the

questionnaire. Third, the terms "confidential" and "therapist" were defined the first time they were used, to avoid any misunderstanding as to their meaning and reduce error variance due to different subjective interpretations. Other changes included minor alterations in wording to clarify some items, reordering of the items (for smoother transitions between them), and major revisions in the accompanying cover letter (e.g., to satisfy informed consent requirements for participation in research). When all the changes were satisfactory to everyone concerned, test development was considered completed.

Research Participants

In exploring client views on confidentiality it was decided to use clients at North Dakota's Human Service Centers as the research subjects. These facilities, part of the State Department of Human Services, provide a wide range of services: outpatient psychotherapy, aftercare for persons discharged from inpatient treatment, addiction counseling, community consultation, etc. Essentially, they are very comprehensive community mental health centers in terms of the direct clinical services which are provided. This was done because of the researcher's access to this group of individuals, the relevance of the issues to human service/mental health centers, and the fact that a large proportion of outpatient services in the area are provided by such facilities. There were other theoretical and practical reasons for using this setting: confidentiality has been viewed as an important issue in community mental health (Curran,

1969; Jeffrey & Reeve, 1978; Kelley & Weston, 1974a, 1974b, 1975; Lewis, 1967; Shore & Golann, 1969; Szasz, 1966, 1970a), previous research has been done in this type of setting (Angelo, 1978; Appleton, Note 1; Newman, Note 4; Noll & Hanlon, 1976; Rosen, 1976a, 1976b, 1977, 1978a, 1978b), and significant dilemmas have been identified (Jagim et al., 1978; Noll & Hanlon, 1976). It seemed very logical to focus on clients in this type of facility.

The subjects consisted of all new, incoming clients at the participating facilities with the following exceptions: those in acute distress, those who appeared (to the staff member handing out the questionnaire) unable to understand the form and respond meaningfully, and minors or those not legally competent to consent to participation in research. Acutely distressed clients were excluded because filling out the form might have delayed their receiving immediate attention, because they might not have been able to give meaningful responses, and because participation in the study might have exposed them to more than a minimal risk of harm. Several types of individuals were excluded because they probably would not have been able to give valid and reliable responses: those apparently intoxicated, psychotic, developmentally disabled, illiterate, or unable to communicate in English. Clients with handicaps that prevented them from easily reading or writing were excluded because participating would not have been feasible in the normal waiting room environment (e.g., without any special assistance). All minors were excluded because of the focus on adults, to avoid any possible problems regarding consent to participate,

and to simplify test administration.

The operationalized criteria for subject selection and exclusion were placed into the instructions for support staff who handed out the questionnaires (Appendix E). It was stressed to everyone concerned that participation was completely voluntary and that the responses were totally anonymous. Two particular factors suggest the research participants were reasonably well motivated and responded appropriately: 20.7% took the time to write comments or questions, and 29.2% requested the results of the study, even though this meant giving their names and addresses (which they could have thought might jeopardize anonymity). In scoring the questionnaires, it was evident there were very few obvious deleterious response sets (e.g., answering all items with "agree").

The response rate, to the questionnaire and within it was high, the latter being extremely so. A total of 828 questionnaires were sent out to the 7 participating facilities: 247 were returned unused (as they had never been handed out) and 474 were used, which left 107 questionnaires unaccounted for. While some questionnaires may have been taken by curious staff, most were likely taken away by clients who did not have the time or inclination to fill out the form at the participating facility and did not do so afterwards. Nine questionnaires had to be discarded, for example, because they were blank or had been filled out by a client who met the exclusion criteria but participated anyway. Thus there were a total of 465 completed questionnaires usable for analysis. Almost all clients responded to nearly all items: For instance, the smallest number

of clients that responded to any item was 436 and the 20 Likert format items had an average of 457 responses each. Thus there is every reason to be confident of the quality of the responses.

The research participants were clients at seven North Dakota Department of Human Services regional Human Service Centers: Northwest Human Service Center (NWHSC) in Williston, North Central Human Service Center (NCHSC) in Minot, Lake Region Human Service Center (LRHSC) in Devils Lake, Northeast Human Service Center (NEHSC) in Grand Forks, Southeast Human Service Center (SEHSC) in Fargo. South Central Human Service Center (SCHSC) in Jamestown, and West Central Human Service Center (WCHSC) in Bismarck. Of the eight centers in the state, only one did not take part in the study. The sample size was 465. Details on the data collection at each participating facility are presented in Table 1.

Table 1

Details of Data Collection

Center	N	Percentage of Total	Date Started	Date Ended	Length in Days
Northwest	113	24.3	110182	010683	45
North Central	35	7.5	102682	123082	45
Lake Region	30	6.5	102582	013183	67
Northeast	36	7.7	110882	020483	61
Southeast	106	22.8	102582	122982	45
South Central	41	8.8	113082	020283	45
West Central	104	22.4	111582	011983	45
Total	465	100.0	102582	020483	71

Ideally, it would have been best to start and end data collection on the same date at each center, but practical considerations made this impossible. For example, some centers were not able to prepare for data collection as quickly as others because of administrative or clinical factors (such as changes in offices, vacations of key staff, heavy work loads, etc.). As the data collection progressed, significant differences in response rates became apparent between the large and small centers. To have ended on the same day would have meant obtaining a very large number of responses at some facilities and very few at others. To have obtained the same number of responses at each facility, with an adequate overall sample size, would have taken a prohibitive amount of time. Thus a compromise was reached: to run the experiment at each center for 45 working days (inclusive of the starting and ending days), or until 30 responses were obtained, whichever came last. Information about the length of data collection is part of Table 1. Data were also obtained on dates the questionnaire was actually filled out. These are presented in Table 2. Demographic characteristics of the research participants are presented in Chapter 4.

Table 2

Dates of Questionnaire Completion

Variable	Value	N	Percentage
Year	1982	380	84.8
	1983	68	15.2
Month	November	202	45.1
	December	161	35.9
	January	65	14.5
	October	17	3.8
	February	3	.7
Day	Wednesday	113	25.3
	Tuesday	105	23.5
	Monday	103	22.2
	Thursday	58	13.0
	Friday	56	12.5
	Sunday	7	1.6
	Saturday	5	1.1

Experimental Procedure

The experimental procedure consisted of distributing the questionnaire designed to assess views on confidentiality to all newly admitted clients who met the selection criteria described earlier at seven of the eight human service centers in North Dakota. The entire data collection period lasted from October 25, 1982, through February 4, 1983. Specific information regarding the numbers of clients surveyed and the time period involved at each center is presented in Table 1.

Once the cooperation of each participating facility was obtained, a liaison person was designated to coordinate the research

on site. In all but one case this was an experienced clinical psychologist; at one center, it was a senior social worker in the position of clinical director of the agency. The role of this individual was to oversee the experimental phase of the study, in place of the principal investigator (who filled this role himself at one facility). It was felt necessary and highly desirable to have an experienced professional familiar with these issues supervising the collection of the data and dealing with any problems that might arise. Both clients and staff at each facility were given the name of this person to contact in case of any problems or questions. The local contact person instructed the staff members who actually distributed the questionnaire, supervised this process, and returned the test materials at the end of the data collection.

The general procedure was to have a support staff member hand each client (who met the selection criteria) a questionnaire packet when he or she first came to the center (after the client had been greeted). Typically, the client filled out the form in a reception area while waiting for his or her appointment with a professional. The individuals surveyed were coming for clinical services, not others provided by the center. The packets contained a cover letter individualized for each center (e.g., giving the resource person's name), the actual questionnaire, a slip to request results of the study, and an envelope to enclose the questionnaire in once it was completed. It took an average client about seven or eight minutes to complete the form. Once he or she finished, the instructions called for the form to be handed in to the person who gave it to

him/her or placed in a collection box. Clients could also take the form with them and return it at their next visit, or else mail it in (as 16 did).

The specific procedures varied somewhat from center to center, for example, in terms of who handed out the form (at one facility it was a professional intake worker during the intake interview) and how it was to be returned (at another facility to the therapist). As noted previously, the cover letters and instructions to staff distributing the questionnaire were personalized for each center. Although the specific procedures varied somewhat, in each case, the questionnaire was to be completed before the client's first actual therapeutic contact. Data collection was uneventful.

There were several reasons for distributing the questionnaire prior to the first actual therapy session. For one thing, there is reason to believe that views on confidentiality may vary throughout the therapy process: As clients keep coming back, trust should deepen and concern about confidentiality may change. It was felt important to survey all clients at the same point in treatment and right at the start seemed like a very logical choice. Asking clients to participate in research during ongoing therapy would likely have some sort of effect on the treatment process; it was felt desirable to avoid any possible interference in ongoing treatment. Finally, concerns about confidentiality at the very start of treatment are of intrinsic interest because they may be a very real factor in whether or not the client even comes in or returns after the first appointment.

Data Analysis

After the completion of data collection at each facility, the questionnaires were returned to the investigator who scored them by hand and recorded the numbers directly onto keypunch scoring sheets. These were sent, in a group, to the computer center at North Dakota State University (NDSU), where they were keypunched and entered directly into the researcher's disc library on the IBM 4341 computer. The data were accessed and programs run through the VSPC (Virtual Storage Personal Computing) timesharing system. The NDSU computer center provides these services for all state colleges and universities through the Higher Education Computer Network (HECN). Timesharing terminals at Minot State College were used for remote job entry of programs.

Data were analyzed by means of a widely used software package, the Statistical Package for the Social Sciences (SPSS), Version H, Release 9.1 (Hull & Nie, 1981; Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975). The following specific subprograms were used: Factor Analysis, Frequencies (providing frequency distributions and many other summary statistics), Oneway (providing oneway analyses of variance), Pearson Correlation, Reliability (yielding test reliability data), and T-Test (providing various *t* and *F* tests). All of these statistical techniques are in common use and fully explained in various standard texts. The results of these analyses are presented in the next chapter.

CHAPTER IV

RESULTS

This chapter presents the results of the study. The first section deals with the research participants, for example, their demographic characteristics and confidentiality related experiences. The second section describes the characteristics of the test developed to assess client views on confidentiality. Specifically, it deals with the statistics of the individual items, the reliability of the scale, and its factor structure. The third part presents the general results of the study in terms of the experimental hypotheses. And the final section analyzes the research participants' comments and questions.

Because of the length and complexity of the supporting data, many of them are presented in the form of reproductions of computer printouts in Appendices I through L. Appendix G contains the verbatim written responses of the research participants. Appendix H provides a key to the computer output. All of the results are based upon computer analysis of the data using various SPSS statistical subprograms.

Research Participants

Demographic characteristics of the 465 human service center clients who participated in the research are presented in Table 3.

Table 3

Demographic Characteristics of Research Participants

Variable	Mean	Median	Mode	Standard Deviation	Range
Age	31.5	29.9	26.0	9.4	18-60
Education	12.9	12.4	12.0	2.1	5-22
SIOPS Score	41.0	41.0	41.0	10.6	14-78

Variable	Value	N	Percentage
Sex	Female	261	57.0
	Male	197	43.0
Race	White	431	92.7
	Native American	19	4.1
	Black	1	.2
	Hispanic	1	.2
Marital Status	Married	236	51.5
	Single	114	24.9
	Divorced	66	14.4
	Separated	35	7.6
	Widowed	7	1.5

They ranged in age from 18 to 60, with a mean of 31.5. The clients were generally well educated, with a mean number of years of schooling of 12.9 (and a range of 5 to 22). The majority were female, 57.0%, but this was not as large a disparity as had been expected, given the common belief that many more females seek services than males. Nearly all of the clients, 92.7%, were White; the only other racial group represented in any significant numbers was Native American (or Indian), consisting of 4.1% of the respondents. Most clients were either married (51.5%), single (24.9%), or divorced (14.4%).

Occupational data were collected to better describe the participants and for use in creating a measure of socioeconomic status. Given the complexity of the latter, theoretically and practically, it was instead decided to use an occupational prestige measure. Treiman's (1977) Standard International Occupational Prestige Scale, SIOPS, was chosen because of its quality, recency, and comprehensiveness (classifying many more occupations than other scales). In the scoring of the questionnaires, each occupation was assigned a unique code; subsequently, it was very easy to give each subject an occupational prestige score (based upon Treiman's scale). SIOPS scores range from -2, for food gatherer, the lowest ranked occupation, to 82, for Supreme Court justice, the highest ranked one.

Table 4 lists the 20 most frequently encountered occupations in the study. These also turned out to be all categories with five or more persons in them. The SIOPS scores associated with these particular occupations are included in Table 4, while overall SIOPS scores are presented in Table 3. There was considerable diversity of occupations among the 436 research participants who gave scorable responses to this question. These individuals held 111 different types of jobs in all of the major occupational categories (such as professional, technical and related workers; service workers; and clerical and related workers).

Table 4

Occupations of Research Participants

Occupation	N	Percentage	SIOPS Score
Homemaker	79	18.1	41
Student	29	6.7	41
Unemployed	22	5.0	41
Farmer or Rancher	16	3.4	47
Teacher	15	3.2	62
Secretary	13	3.0	53
Salesperson	13	3.0	34
Registered Nurse	10	2.3	54
Construction Worker	10	2.3	26
Laborer	9	1.9	19
Office Clerk	9	1.9	43
Oil Field Worker	9	1.9	31
Waiter or Waitress	9	1.9	23
Orderly or Aide	8	1.7	42
Driver	8	1.7	33
Cook	6	1.4	31
Manager	6	1.4	60
Mechanic	6	1.4	43
Sales Worker	6	1.4	40
Welder	6	1.4	39
Other	147	33.7	--

Information on factors related to treatment is presented in Table 5. Although most clients were coming to the center for the first time (73.0%), a surprisingly large number had previous treatment (52.3%) either at that center (27.0%) or elsewhere (39.2%) and some had both. Most were coming voluntarily (82.9%), but if involuntary entry was redefined as referral by police or court, that percentage fell (to 79.8%). Most clients either came by themselves (33.9%), or were referred by a family member or friend (22.7%), or the court or police (20.2%). Most of those referred by the criminal justice system probably came for routine evaluation, education, and

treatment following conviction for driving while under the influence of alcohol. Many centers offer special classes or other interventions for these individuals which are not psychotherapeutic in intent, but nevertheless constitute a significant part of a facility's outpatient services.

Table 5

Factors Related to Treatment of Research Participants

Variable	Value	N	Percentage
Previous Treatment	Same Facility	124	27.0
	Other Facility	179	39.2
	Any Facility	239	52.3
Entry Status	Voluntary	373	82.9
	Involuntary	77	17.1
Referral Source	Self	149	33.9
	Family Member/Friend	100	22.7
	Police/Court	89	20.2
	Physician	26	5.9
	Social/Human Services	18	4.1
	Hospital	15	3.4
	School/Teacher	11	2.5
	Employer	6	1.4
	Counselor/Therapist	5	1.1
	Other	21	4.8

Table 6 presents data on factors related to confidentiality experiences of the clients. A surprisingly large number, 29.4%, stated they had gone to a minister, priest, or rabbi for help with personal problems because of absolute confidentiality in that relationship. Another large number, 20.8%, stated they had hesitated to see a therapist because of concerns about confidentiality, and 9.8% indicated they had been in a situation where confidentiality had

been broken. If informed that there would be no confidentiality in therapy, 77.0% indicated they would either avoid treatment entirely or be less open in what they talked about.

Table 6

Factors Related to Confidentiality of Research Participants

Variable	Value	N	Percentage
Use of Minister	Yes	134	29.4
	No	322	70.6
Hesitation to See Therapist	Yes	94	20.8
	No	357	79.2
Confidentiality Breached	Yes	44	9.8
	No	405	90.2
Action if No Confidentiality	Avoid Treatment	201	45.4
	Be Less Open	140	31.6
	No Difference	79	17.8
	Be More Open	23	5.2

Measurement Instrument

A significant part of this study involved developing an instrument to assess client attitudes toward confidentiality, with an emphasis on issues associated with psychotherapy in an outpatient setting. Strictly speaking, the attitude scale consists of the first 20 items (all in Likert format) of the questionnaire presented in Appendix B. The other items on the questionnaire are meant to gather demographic information on the respondents (items 1 through 6 and 15, on the third and fourth pages of the form), data regarding current and previous treatment (items 7 through 10), and information

regarding confidentiality related experiences (items 11 through 14).

A summary of the responses to each of the 20 attitude scale items is presented in Table 7. More detailed descriptive statistics (e.g., measures of central tendency and variability) are presented in Appendix I.

Table 7

Responses on Attitude Scale

Item Number	Item Content	Response Category				
		SA	A	N	D	SD
1.	A client should not have access to his/her file.	4.5	12.7	12.7	41.3	28.6
2.	Therapists should disobey court orders to reveal information about clients.	27.5	34.6	21.0	14.1	2.8
3.	Openness and confidentiality are essential in therapy.	61.5	33.3	3.2	.9	1.1
4.	Confidentiality should be broken to preserve national security.	14.9	40.6	25.0	12.9	6.6
5.	Teenagers should not have confidentiality.	3.7	12.3	12.3	44.0	27.8
6.	Confidentiality should be broken to prevent suicide.	25.3	53.3	13.0	6.0	2.4
7.	Information about clients should be sent to a central registry.	1.1	14.3	17.5	35.2	32.0

Table 7 (Continued)

Responses on Attitude Scale

Item Number	Item Content	Response Category SA	A	N	D	SD
8.	Confidentiality should be broken to prevent drunk driving.	9.7	35.7	24.2	24.9	5.5
9.	Clients assume confidentiality.	36.8	51.0	7.4	4.6	.2
10.	I don't want to be seen coming here.	5.0	14.0	38.6	34.9	7.5
11.	A therapist is obligated to maintain confidentiality.	38.7	53.4	6.2	1.3	.2
12.	Confidentiality should be absolute.	34.2	41.3	12.4	11.7	.4
13.	Therapists should keep careful records on clients.	34.9	58.6	4.8	1.5	.2
14.	Child abusers should be reported to the authorities.	29.3	45.0	16.9	8.0	.9
15.	Impaired employees in sensitive jobs should not have confidentiality.	14.8	45.1	25.4	12.6	2.0
16.	Apprehension of criminals is not justification for breach of confidentiality.	9.9	27.9	36.4	21.6	4.3
17.	I prefer confidentiality.	40.1	46.6	11.8	1.5	0

Table 7 (Continued)

Responses on Attitude Scale

Item Number	Item Content	Response Category SA	A	N	D	SD
18.	Clients should be informed about limits on confidentiality.	34.1	58.9	5.3	1.5	.2
19.	Confidentiality should not be broken to safeguard threatened third parties.	1.8	6.2	18.7	53.3	20.0
20.	Therapists should consult with each other.	15.6	57.9	16.9	7.5	2.2

Note. Numbers represent percentages in each of the 5 response categories (SA = strongly agree, A = agree, N = neutral, D = disagree, and SD = strongly disagree) adjusted for missing cases.

As noted previously, the items were scored in a pro-confidentiality direction, on a scale of one to five, with five representing the sentiment most associated with a strong pro-confidentiality position. The "strongly disagree" end of the scale was scored a five for the following items: 1, 4, 5, 6, 7, 8, 13, 14, 15, and 20. "Strongly agree" was scored a five for these items: 2, 3, 9, 10, 11, 12, 16, 17, 18, and 19. A rank ordering of the items, in terms of mean scores, is presented in Table 8. All of the item means differ significantly from a completely neutral position (a score of 3.000) and from the overall mean for the scale (3.233). In

terms of percentages of responses, the research participants had fairly strong opinions on most of the items: On only three items (numbers 8, 10, and 16) did less than 50% of the clients fail to clearly agree or disagree with the matter in question (where agree and disagree are the "strongly agree" and "agree" categories combined, or the "strongly disagree" and "disagree" categories, respectively).

Table 8

Rank Ordering of Attitude Scale Items

Rank	Item Mean	Item Number	Item Content
1.	4.533	3.	Openness and confidentiality are essential in therapy.
2.	4.291	11.	A therapist is obligated to maintain confidentiality.
3.	4.253	17.	I prefer confidentiality.
4.	4.251	18.	Clients should be informed about limits on confidentiality.
5.	4.195	9.	Clients assume confidentiality.
6.	3.971	12.	Confidentiality should be absolute.
7.	3.827	7.	Information about clients should not be sent to a central registry.
8.	3.800	5.	Teenagers should have confidentiality.
9.	3.769	1.	A client should have access to his/her file.
10.	3.699	2.	Therapists should disobey court orders to reveal information about clients.
11.	3.175	16.	Apprehension of criminals is not justification for breach of confidentiality.

Table 8 (Continued)

Rank Ordering of Attitude Scale Items

Rank	Item Mean	Item Number	Item Content
12.	2.808	8.	Confidentiality should be broken to prevent drunk driving.
13.	2.743	10.	I don't care about being seen coming to a treatment facility.
14.	2.557	4.	Confidentiality should be broken to preserve national security.
15.	2.418	15.	Impaired employees in sensitive jobs should not have confidentiality.
16.	2.228	20.	Therapists should consult with each other.
17.	2.164	19.	Confidentiality should be broken to safeguard threatened third parties.
18.	2.069	6.	Confidentiality should be broken to prevent suicide.
19.	2.062	14.	Child abusers should be reported to the authorities.
20.	1.737	13.	Therapists should keep careful records on clients.

Note. Items are ranked on a scale of 1 to 5 where 5 represents a pro-confidentiality position and 1 represents an anti-confidentiality position.

Reliability data on the test are presented in Appendix J. The reliability of the test, based on a measure of internal consistency, is fairly high: Cronbach's coefficient alpha is .77. Inter-item correlations, on the other hand, are low, with a mean of .144 and the following other statistics: minimum, -.317; maximum, .563;

range, .880; and variance, .022. The individual inter-item correlations are listed in Appendix K, as part of a table of intercorrelations of all the variables in the study. Appendix J also lists the item-total correlation for each item, partialing out its contribution to the total score. It should be noted that these data were computed using a summary measure of confidentiality, the intermediate score (labelled X32 on the printouts). This is simply the sum of all the individual item scores, taking into account missing cases.

In passing, it should be noted that another composite measure (labelled X31 on the computer output) was created to summarize views toward confidentiality. It is the average of the individual item scores, taking into account missing cases. Further use was not made of this measure because of concerns about its validity in terms of scale construction techniques. For example, given the apparent heterogeneity of the items, it was felt inappropriate to simply combine them arithmetically into one overall measure of concern about confidentiality.

A factor analysis of the test was also performed using the principal axis method, without iterations, and a varimax rotation. These results are presented in Appendix L. Four main factors were identified, which together accounted for 47.6% of the variance in the item scores. The items with significant factor loadings on each of the four factors are rank ordered in Table 9, following a common convention that only factor loadings of larger than .30 have much practical significance. According to this criterion, nine items

loaded significantly on the first factor, eight on the second, and three each on the third and fourth factors. These factors appear fairly homogeneous and have a plausible common sense interpretation.

Table 9

Factors and Rotated Factor Loadings

Factor	Item Number	Item Subject	Rotated Factor Loading
I.	17.	Client Preference	.730
	11.	Therapist Obligation	.716
	12.	Absolute Confidentiality	.700
	9.	Client Expectation	.623
	3.	Openness	.609
	18.	Informed Consent	.484
	16.	Crime Control	.471
	2.	Court Order	.461
	5.	Teenager Confidentiality	.329
II.	15.	Sensitive Job	.745
	14.	Child Abuse	.701
	19.	Tarasoff Obligation	.676
	4.	National Security	.636
	6.	Suicide Prevention	.630
	8.	Traffic Safety	.621
	16.	Crime Control	.479
	5.	Teenager Confidentiality	.372
III.	1.	Record Access	.725
	7.	Central Registry	.563
	18.	Informed Consent	.437
IV.	20.	Consultation	.735
	13.	Record Keeping	.499
	10.	Privacy	.427

The first factor was named the Preference/Expectation factor. Basically, the items with the highest loading on it (numbers 17, 11, 12, 9, 3, 18, 16, 2, and 5) seem to reflect preferences or expectations of clients regarding confidentiality. For example, the

contents of the four highest loaded items are the following: Clients prefer confidentiality to exist, clients believe therapists have an obligation to maintain confidentiality, confidentiality should be absolute, and clients expect what they say to remain confidential.

The second factor was named the Breaking Confidentiality factor. Quite clearly, it reflects the situations in which clients feel confidentiality should be broken: to protect the welfare of individuals who might be hurt by an impaired employee, to prevent child abuse, to safeguard a third party threatened by a client, to protect national security, to prevent suicide, and to apprehend criminals and thus control crime. Eight items load significantly on this factor: 15, 14, 19, 4, 6, 8, 16, and 5.

Three items (1, 7, and 18) load significantly on the third factor, which was named the Record Access factor. The content of these items is as follows: Clients should have access to their records, personally identifiable data on clients should not be sent to a central registry, and clients should be informed about limits on confidentiality.

The fourth factor, Privacy, has to do with personal privacy at a treatment facility. Three items (20, 13, and 10) have significant loadings on this factor. Basically, clients do not feel that therapists consulting with each other about a case, thorough record keeping, or others seeing them at the facility constitute significant invasions of privacy.

In summary, the 20-item test appears to be a fairly reliable one, with a distinct 4 factor structure, that elicits clear responses from clients.

Tests of Hypotheses

The specific experimental hypotheses formulated in Chapter 2 can be evaluated in terms of five basic areas: the relationship between demographic factors and attitudes toward confidentiality, the effect of factors related to treatment on these attitudes, the relationship between confidentiality related experiences and attitudes, the circumstances under which confidentiality should be broken, and miscellaneous aspects of the topic.

Most of the hypotheses were tested by means of one or more of the following statistics: simple descriptive statistics, product moment correlations, and *t* tests. Tables 7 and 8, and Appendices I and K contain many of the specific data. All statistical tests are one-tailed unless otherwise noted. Given the lack of a single simple overall measure of confidentiality, the discussion often centers on the relationship between each individual attitude scale item and whatever other variable is of interest.

Demographic Factors

There were gender differences on 6 of the 20 attitude scale items: Females felt that openness is more essential to successful treatment, $t(387) = 2.43$, $p = .008$. Females were more in favor of teenagers having confidentiality when it comes to their parents,

$t(455) = 2.39$, $p = .009$. Females favored suicide prevention more, even if confidentiality must be breached, $t(454) = -2.25$, $p = .013$. Females were more opposed to information about clients being sent to a central registry, $t(454) = 2.59$, $p = .005$. Females were more in favor of therapists keeping thorough records on clients, $t(448) = -2.19$, $p = .015$. Females were more in favor of informed consent procedures regarding limits on confidentiality, $t(452) = 2.14$, $p = .017$. Also, females stated they would be more deterred from entering treatment by a lack of confidentiality, $t(434) = 1.83$, $p = .034$.

Age was generally inversely correlated with concern about confidentiality: older clients were more likely to favor a therapist disclosing information under court order ($r = -.099$, $p = .018$), breach of confidentiality to protect national security ($r = -.097$, $p = .020$), consultation between colleagues ($r = -.094$, $p = .023$), and informing a teenage client's parents about their child being in treatment ($r = -.200$, $p < .001$).

Educational level, on the other hand, tended to be positively correlated with concern about confidentiality in the following areas: national security, ($r = .141$, $p = .002$), teenage client's privacy ($r = .172$, $p < .001$), sending data on clients to a central registry ($r = .234$, $p < .001$), preservation of traffic safety ($r = .179$, $p < .001$), notifying employers of impaired clients in sensitive jobs ($r = .176$, $p < .001$), and informed consent ($r = .118$, $p = .007$). Better educated research participants favored clients' access to their own records ($r = .096$, $p = .022$), felt confidential-

ity was more essential for successful treatment (r = .079, p = .048), tended not to want to be seen coming to a treatment facility (r = .177, $p < .001$), had more of a feeling that therapists were obligated to preserve confidentiality (r = .165, $p < .001$), and expressed more of a preference for confidentiality (r = .078, p = .050).

Race was a significant factor in only four scale items: traffic safety, $t(440) = 2.39$, p = .009; record keeping, $t(442) = 1.98$, p = .025; sensitive employment, $t(438) = 4.19$, $p < .001$; and consultation with colleagues, $t(448) = 1.71$, p = .045. In each case, Whites favored confidentiality more than Non-whites. However, the generalizability of these results may be limited because of the very small size of the latter group (21) compared with the former (431), and the fact that almost all were Native Americans; thus the comparison is between that group and Whites.

Marital status, married vs. non-married, was relevant only in two respects: married persons were more opposed to information being sent to a central registry, $t(454) = -1.67$, p = .048; while single persons were more favorably inclined to teenage clients having privacy with respect to their parents, $t(455) = 2.01$, p = .023.

Contrary to expectation, occupational prestige was generally inversely correlated with concern about confidentiality in the areas of therapists obeying a court order to disclose information about a client (r = -.099, p = .020), notifying others to prevent a suicide (r = -.127, p = .004), keeping thorough records (r = -.130, p = .003), and maintaining absolute confidentiality (r = -.163, $p < .001$).

On the other hand, clients with more prestigious jobs preferred not to be seen coming for treatment ($r = .189$, $p < .001$) and felt therapists had an obligation to maintain confidentiality ($r = .098$, $p = .022$).

Treatment Related Factors

First admissions to a center were more interested in knowing the limits on confidentiality, $t(447) = -1.81$, $p = .035$; wanted therapists to disobey court orders mandating release of information about clients more, $t(454) = -1.90$, $p = .029$; and were more opposed to therapists warning endangered third parties than those re-admitted to the facility, $t(442) = -2.87$, $p = .002$. Re-admissions, however, were more interested in clients having access to their records, $t(260) = 2.29$, $p = .012$.

Clients with previous treatment elsewhere more strongly favored absolute confidentiality, $t(443) = 2.48$, $p = .007$, and were much more interested in being informed about any limits on confidentiality, $t(414) = 4.03$, $p < .001$. This finding was repeated for those who had any prior treatment, either at the facility they came to or another: $t(443) = 1.99$, $p = .024$ and $t(445) = 1.82$, $p = .035$, respectively. In contrast to this, those with prior treatment felt therapists should obey court orders and divulge information on clients, $t(450) = -2.21$, $p = .014$, and warn endangered victims, $t(440) = -1.86$, $p = .032$.

Self-referred clients were more in favor of suicide prevention, $t(349) = 3.09$, $p = .001$; record keeping, $t(430) = 2.67$, $p = .004$;

warning intended victims, $t(427) = 2.14$, $p = .017$; but less in favor of confidentiality in the abstract, $t(434) = -1.82$, $p = .035$; and less likely to hold a therapist obligated to maintain confidentiality, $t(431) = -1.97$, $p = .025$.

Surprisingly, clients coming to a center voluntarily were more concerned about confidentiality, in three respects, than those forced to come. They were more opposed to sending information to a central registry, $t(446) = 2.14$, $p = .017$; expressed a greater preference for confidentiality, $t(442) = 2.79$, $p = .003$; and tended more to feel that the therapist had an obligation to maintain confidentiality, $t(440) = 2.65$, $p = .004$. However, they were more in favor of suicide prevention, $t(446) = -2.90$, $p = .002$.

When involuntary entry was redefined as referral by the police or a court, similar findings emerged. Voluntary referrals showed less interest in protecting national security, $t(429) = 2.28$, $p = .012$; and having information sent to a central registry, $t(436) = 1.65$, $p = .050$. They felt more that therapists were obligated to preserve confidentiality, $t(431) = 2.26$, $p = .012$; showed a greater preference for confidentiality, $t(434) = 2.90$, $p = .002$; and were more interested in informed consent, $t(430) = 2.58$, $p = .005$.

Confidentiality Experience Factors

Experiences related to confidentiality were generally very closely related to attitude scale items. Clients who had used a minister, priest, or rabbi for help with personal problems, because of a desire for complete confidentiality, were more favorably inclined

toward confidentiality in the following situations: preservation of national security, $t(445) = 1.98$, $p = .025$; sending personally identifiable data to a central registry, $t(452) = 2.25$, $p = .013$; teenage client's privacy, $t(453) = 1.76$, $p = .040$; therapist's obligation to maintain confidentiality, $t(446) = 2.49$; $p = .007$; desire for absolute confidentiality $t(442) = 2.99$, $p = .002$; traffic safety, $t(443) = 1.75$, $p = .041$; crime control, $t(434) = 2.21$, $p = .014$; preference for confidentiality, $t(448) = 2.65$, $p = .004$; and warning endangered third parties, $t(439) = 2.03$, $p = .022$.

Clients who hesitated to seek treatment were even more in favor of confidentiality, as seen in significant differences between them and those who had not hesitated on 14 of 20 scale items: court order, $t(446) = 2.11$, $p = .018$; openness, $t(449) = 2.76$, $p = .003$; national security, $t(440) = 2.37$, $p = .009$; suicide prevention, $t(115) = 2.29$, $p = .012$; central registry, $t(159) = 3.75$, $p < .001$; privacy, $t(441) = 3.86$, $p < .001$; therapist obligation, $t(441) = 3.87$, $p < .001$; absolute confidentiality, $t(437) = 3.20$, $p < .001$; child abuse, $t(435) = 1.79$, $p = .038$; crime prevention, $t(429) = 3.82$, $p < .001$; preference, $t(183) = 3.70$, $p < .001$; informed consent, $t(183) = 2.09$, $p = .019$; duty to warn, $t(124) = 1.70$, $p = .046$; and consultation, $t(128) = 2.95$, $p = .002$.

The most frequent correlations between the scale items and another variable were with the perceived deterrent effect of a lack of confidentiality upon entry into treatment. Clients who stated they would be deterred by a lack of confidentiality were more concerned about it on 19 of the 20 scale items than those who stated

they would not be deterred. This can be seen by examining the correlation of variable Y19 in the printout in Appendix K with variables X1 through X20, the scale items. The only item without a significant correlation was the one having to do with record keeping, $\underline{r}$ = .019, $\underline{p}$ = .349.

As noted previously, a significant number of the respondents, 29.4%, reported using a minister/priest/rabbi for help with personal problems because of the absolute confidentiality in such a relationship. A slightly smaller number, 20.8%, stated they had hesitated to see a therapist out of concern about confidentiality. Almost 10% of the clients reported being in a situation where confidentiality had been breached. If informed there would be no confidentiality in a therapeutic relationship, 45.4% predicted they would avoid treatment, while 31.6% stated they would enter but be less open in what they discussed; only 17.8% stated this would have no effect on them.

Circumstances Under Which Confidentiality Should be Broken

As expected, clients have differing attitudes on the value of confidentiality depending on the situation. The data in Tables 7 and 8 are of particular relevance in determining the circumstances under which clients feel confidentiality should be broken. Generally, the respondents favor confidentiality but are willing to have it broken in some cases, particularly in order to prevent harm to someone. In the discussion that follows, the Likert categories "agree" and "strongly agree" are collapsed into an "agree" category, while

"disagree" and "strongly disagree" will simply be referred to as "disagree".

Surprisingly, 62.1% of the respondents felt that a therapist should maintain confidentiality even if ordered by a court to disclose information regarding a client. On the other hand, 55.5% believed therapists should report clients who are security risks to the proper authorities. Teenagers are felt to have a right to confidentiality in regard to their parents: 71.8% thought a therapist should not disclose information about a teenage client to his or her parents without permission.

Clients fairly strongly (78.6%) believe that a therapist should act to prevent a client's suicide even if it means breaking confidentiality. Maintenance of fiscal and administrative accountability, is not adequate justification to 67.2% of the respondents for agencies to send personally identifiable data regarding clients to a central registry. To preserve traffic safety by reporting clients who drive while under the influence of alcohol is unacceptable to 30.4% of the research participants (the rest favoring such a practice or being neutral).

Prevention of child abuse, by the reporting of clients who engage in such behavior, is acceptable to 74.3% of the subjects in this study. They are more neutral, however, about breaking confidentiality to help the authorities apprehend persons who have committed a serious crime, only 25.9% favoring such action.

At times, a client who has a sensitive occupation may be so impaired as to threaten the wellbeing of those he or she comes in

contact with on the job. In such cases, 59.9% of the respondents feel confidentiality should be broken to prevent harm to the persons who might be affected. To prevent serious harm to a third party threatened by a client, 73.3% of the respondents felt confidentiality should be broken.

Consultation of a therapist with colleagues is felt to be a justifiable practice to 73.5% of the subjects even with the loss of some privacy. Despite allowing all these exceptions to confidentiality, 75.7% feel that it should indeed be absolute.

Miscellaneous Aspects of Confidentiality

Of the 20 items on the scale, the one that received the highest score was the one having to do with the importance of openness in treatment: 94.8% of the respondents felt that for a therapist to help a client the client must be able to speak freely and not worry about possible breaches of confidentiality. They overwhelmingly indicated confidentiality was important and relevant. This is also seen in the fact that 77.0% predicted they would either avoid treatment entirely or be less open without a guaranty of confidentiality. Interestingly, 87.8% stated clients naturally assume there is complete confidentiality in therapeutic relationships.

The item with the second highest score was the one referring to a therapist's obligation to maintain confidentiality: 92% stated a professional had such an obligation. The third highest ranked item had to do with clients' preference for confidentiality: 86.7% said they wanted what happened at the treatment facility to remain

confidential, while only 1.5% expressed the opposite preference. The fourth highest ranked item concerned informed consent: 93.0% wanted to be informed about any limits on confidentiality.

As noted previously, clients' attitudes about confidentiality appear relative to the context and not absolute. They are congruent with many legal decisions and professional practices (such as laws mandating reporting of child abuse, and agency record keeping practices) but not with all of these. For example, clients feel that a court order is not sufficient reason to break confidentiality and believe teenagers should have a right to privacy from their parents (even though most laws reject this notion).

Clients generally want to have the right of access to their records, 69.9% endorsing this position. The vast majority of clients, 93.5%, feel that therapists should keep thorough records. Clients are relatively unconcerned about incidental loss of privacy, such as being recognized by someone they know in a waiting room, or at least this is what 42.4% say. However, this may be an underestimate of their true concern, as the form was filled out in the waiting room and it may have been difficult for the clients to admit any discomfort they felt (e.g., in terms of cognitive dissonance and demand characteristics).

While not directly related to any particular experimental hypotheses, the following significant correlation coefficients, from Appendix K, may be of some interest: females were older ($r = -.09$, $p = .028$), better educated ($r = -.100$, $p = .017$), had higher occupational prestige ($r = -.186$, $p < .001$), and were less likely to

be coming involuntarily (r = .298, $p < .001$) than males. Older clients were more likely to have used a minister for help with personal problems (r = -.137, p = .002), less likely to have come involuntarily (r = -.086, p = .036), had occupations with less prestige (r = -.137, p = .002), and were more likely to be married (r = .340, $p < .001$) than younger clients.

Better educated clients were more likely to be voluntary admissions (r = -.118, p = .007), more deterred from seeking treatment by lack of confidentiality (r = -.149, p = .001), more likely to comment or ask a question on the form (r = -.100, p = .018), and had jobs with higher prestige (r = .443, $p < .001$).

Clients who came to the facility for the first time were less likely to have had treatment elsewhere (r = .150, p = .001) and more likely to have consulted a minister because of concerns about confidentiality (r = .102, p = .015). Those who had treatment elsewhere were also more likely to have used a minister for help with personal problems (r = .164, $p < .001$), and were more likely to have been in a situation where confidentiality was broken (r = .238, $p < .001$), but had not been more hesitant to seek treatment (r = .074, p = .060).

Clients coming voluntarily were more likely to have used a minister for help (r = .125, p = .004), had hesitated more to seek treatment (r = .094, p = .023), were much less likely to have been referred by a court or the police (r = .749, $p < .001$), and had a higher occupational prestige (r = -.183, $p < .001$).

Those who had gone to a minister/priest/rabbi for help out of

concern about confidentiality hesitated more to seek treatment (r = .194, $p < .001$), had been in situations where confidentiality had been broken more often (r = .218, $p < .001$), and predicted they would be more deterred from seeking treatment by a lack of confidentiality (r = -.104, p = .015).

Respondents who in the past had hesitated to seek treatment were more likely to have been in a situation where confidentiality was broken (r = .253, $p < .001$), and stated they would be more deterred by a lack of confidentiality in seeking treatment (r = .120, p = .006).

Analysis of Clients' Comments

Although analysis of clients' written responses to the questionnaire item soliciting comments or questions is necessarily subjective, it can be of value, especially in terms of complementing the other responses and placing them in some context. They are recorded, verbatim, in Appendix G. On the whole, they are interesting and thought provoking.

Basically, it certainly seems that confidentiality is an important and relevant issue for clients. They associate it very closely with the ability to be open in therapy, which is a connection professionals also frequently make. Without some assurance of confidentiality, clients state they would be reluctant to discuss their problems, which is a major reason they came to treatment. The importance of confidentiality to some clients is conveyed by comments such as these: "I think that without confidentiality this program would be out of business," and "Lord help the therapist who breaks

anonymity."

On the other hand, it is very clear that confidentiality is contextual and relative for most clients. As one client stated, "this is a very touchy subject because every situation is different and who is to decide what is right in every situation." Generally, the basic, and sometimes only, rationale for breaking confidentiality seems to be to prevent serious harm to the client or some innocent third party whose welfare might be threatened by the client. Another decision rule seems to be to break confidentiality if and only if it will help the client. This was a point frequently made by participants in the pretesting, that whatever the therapist does should be aimed at serving the best interests of the client. If information is released, it should be limited to what is relevant and the party receiving it should protect the client's privacy as much as possible. Clients place trust in the integrity and good judgement of therapists.

A wide range of sophistication on the part of clients is readily apparent, both in terms of the quality of the writing and the incisiveness of their thinking. While many were unfamiliar with applicable policies and laws, they expressed interest in knowing them; for example, several asked specific questions about agency policies and procedures, and suggested that clients routinely be informed about these (e.g. by being given brochures covering these topics).

Many seemed aware of the complexities involved and the various competing interests a therapist is called to serve. One client, for

example, raised the question of the therapist's own personal values and the possibility of a conflict between them and the law or typical professional practices. Another client offered a good solution to the problem of what to do when it seems information should be released (say to an employer), make this the client's obligation and not the therapist's. Perhaps the most relevant comment was "like everything else, confidentiality should be tempered with common sense."

CHAPTER V

DISCUSSION

This final chapter discusses the results of the study, offers suggestions for further research, and considers some of the implications of the findings. The discussion of the results is divided into five sections: an overview of the findings, review of the circumstances under which clients feel confidentiality could and/or should be broken, examination of other aspects of confidentiality, consideration of the influence of demographic and other factors on attitudes toward confidentiality, and review of the specific experimental hypotheses. Throughout, comparisons are made with previous studies and differing views of professionals on this topic. Suggestions are offered for further research that would increase understanding of confidentiality and patient rights issues, in general. Finally, the implications of the results are discussed, for example, in terms of the double agent role of the therapist and his or her function as an agent of social control.

Discussion of Results

Overview

The major finding of this study is that clients at human service/ mental health centers do indeed care about confidentiality. This is

consistent with the view of many observers (e.g., Berlin, 1973; Huffman, 1972; Morrison et al., 1975; Rumsey, 1974; Tiemann, 1964) and the results of previous studies (e.g., Appleton, Note 1; Marsh & Kinnick, 1970; Meyer & Smith, 1977; Rosen, 1976a, 1976b, 1977, 1978a, 1978b; Roth et al., 1980; Stevens & Shearer, Note 6; Woods, 1977/1978; Woods & McNamera, 1980). On the other hand, this is contrary to what others have predicted or found (e.g., Angelo, 1978; Garfield & Wolpin, 1963; Lewis & Warman, 1964; Modlin, 1969, 1973; Simmons, 1968; Slovenko, 1977; Slovenko & Usdin, 1963).

Despite the high value clients place on confidentiality, they are willing to have it broken in some circumstances, particularly when the safety of third parties is involved. For example, they feel child abuse should be reported, suicide prevented, and threatened third parties protected, even if these actions necessitate breach of confidentiality. To these clients, confidentiality is not an absolute, it is situational and relative to a given context. This is in contrast to the views of some professionals who feel confidentiality should be absolute (e.g., Hollender, 1965; Siegel, 1976; Szasz, 1962; X, 1965). As pointed out earlier, this is fundamentally a question of values, so the difference does not by any means render the absolutist position untenable. Ethical matters are not decided by popular vote, but when issues highly relevant to clients are involved it is logical that their views should be solicited.

Given that clients are concerned about confidentiality, does this have any practical significance? The answer again is yes. Concern about confidentiality does have an effect on behavior. First of all,

a surprisingly large number of clients, 29%, reported they sought assistance with personal problems from a minister, priest, or rabbi because of the absolute confidentiality in such a relationship. The inference is that they did not consult a mental health professional because of concerns about confidentiality. This hypothesis is strengthened by the finding that 21% of the respondents specifically stated they hesitated to see a therapist because they were not sure what they disclosed would be kept confidential. Third, 77% indicated they would either avoid treatment or be less open if informed there would be no confidentiality in a therapeutic relationship. While an individual's prediction of what he or she would do does not necessarily coincide with actual behavior, this finding is consistent with several other studies (Meyer & Smith, 1977; Wise, 1978; Woods, 1977/1978; Woods & McNamera, 1980). It certainly appears that actual or perceived lack of confidentiality does affect clients' behavior.

A third major question is--are clients aware of the real limitations on confidentiality? This is important because a discrepancy between their values and expectations, and the realities of professional practice (particularly in public agencies) could have significant consequences. While this question was not directly addressed, several findings are of some relevance. First of all, 88% of the respondents stated "a client naturally assumes that what he/she tells his/her therapist is completely confidential;" presumably, this includes those participating in the study. Yet complete confidentiality does not exist: The assumption differs from the fact. For example, a significant number of clients, 10%, themselves reported they had been

in a situation where a therapist disclosed what they felt should have been kept secret. A good example of a discrepancy between client preference and professional practice is in terms of sending personally identifiable data regarding clients to a central registry. While 67% of the respondents opposed this, it is a very common practice (Kelley & Weston, 1974a, 1974b, 1975; Newman, Note 4; Noll & Hanlon, 1976). One wonders how many clients are aware of it. Another example has to do with consultation among therapists. While 74% of clients favored this almost universal practice, many commented that clients' names should not be used; yet case staffings often begin with mention of the client's name. These observations and those of others (e.g., Allen, 1973; Bernstein, A. H. 1973; Daley 1975; "Functional overlap," 1962; Wise, 1978) suggest clients may not be aware of actual limits on confidentiality.

The last major finding is more on the nature of a metaconclusion: Ethical issues can be addressed in an empirical matter. An instrument was developed to assess client views on confidentiality. It proved to be reliable and capable of eliciting definite sentiments from actual outpatients. Interesting results came out of the use of this test. Research such as this, for example, might be used to establish ethical codes and administrative regulations on an empirical basis, rather than merely on a speculative on (Meyer & Willage, 1980). Essentially, this was a study in experimental ethics.

Circumstances Under Which Confidentiality Should be Broken

Although 76% of the participants in the study expressed a desire for absolute confidentiality, they were willing to have it broken under the following circumstances: to prevent child abuse, avert a

client's suicide, protect an individual threatened with serious bodily harm by a client, safeguard persons who might be harmed by an impaired employee in a sensitive job, protect national security, and preserve traffic safety by the apprehension of persons driving under the influence of alcohol. It is interesting to note that only a plurality of the respondents, 45%, favored breach of confidentiality to apprehend intoxicated drivers, despite the wide publicity given this subject at the time the data were collected.

On the other hand, clients felt that confidentiality should not be broken by therapists sending personally identifying data to a central registry, informing teenagers' parents that they had come for treatment, obeying a court order to disclose information, or by informing the police if a client admitted committing a serious crime.

There are similarities and differences when these results are compared with other studies. For example, clients are, if anything, more willing to have confidentiality broken in the reporting of child abuse than are professionals (Muehleman & Kimmons, 1981; Swoboda et al., 1978). Clients and professionals agree fairly closely that Tarasoff guidelines should be followed (Fuller, 1972a; Jagim et al., 1978; Stevens & Shearer, Note 6; Tymchuk, et al., 1982; Wiskoff, 1959, 1960) and that suicide should be prevented (Fuller, 1972a; Pulsifer, 1977; Wiskoff, 1959). Clients seem as interested in protecting the privacy of teenage clients as therapists (Melton, 1981; Pulsifer, 1977; Wilson, J. P., 1978). It is interesting that significant numbers of clients and therapists feel that a client's secrets should be protected even in the face of a court order mandating disclosure ("Functional overlap," 1962; Jagim et al., 1978); agencies, however, are much more willing

to obey court orders (Newman, Note 4).

Other Aspects of Confidentiality

Clients, like many professionals, strongly believe that confidentiality is necessary for an effective therapeutic relationship (Jagim et al., 1978; Wise, 1978). There is overwhelming agreement that therapists have a professional and ethical obligation to preserve confidentiality (Jagim et al., 1978; Tymchuk et al., 1982). Eighty-seven percent of the respondents stated they would like what happened at the treatment facility to remain confidential. Clients and many professionals are in close agreement that most clients do expect a high degree of confidentiality (Jagim et al., 1978; Wise, 1978).

One very significant difference between clients and professionals has to do with the common practice of sending personally identifying data to a central registry, often a computer data bank: Clients in this study and in another one (Rosen, 1976a, 1976b, 1977, 1978a, 1978b) strongly oppose this, while agencies routinely do it (Noll & Hanlon, 1976). Noll and Hanlon (1976, p. 1287) found that 36% of the community mental health centers that engaged in this practice did so without the knowledge of the clients involved. This raises the issue of informed consent about confidentiality practices and psychotherapy in general. Ninety-three percent of the participants in this study wanted to be informed about any limits on confidentiality. Therapists, on the other hand, do not seem to place as much emphasis on informed consent: For example, Wise (1978, p. 177) found that only 11% of the therapists she surveyed always discussed the limits on confidentiality

with clients, while 69% did this sometimes.

Seventy percent of the clients surveyed felt they should have access to the files kept on them. This is consistent with an increasing emphasis on client access to records and the positive effects it can have (Abel & Johnson, 1978; Alfidi, 1971; Golodetz et al., 1976; "How to reduce," 1975; Park et al., 1967; Roth et al., 1980; Stein et al., 1979). Relatively few clients were concerned with incidental loss of privacy when coming for treatment, a result consistent with one other study (Garfield & Wolpin, 1963), but not with the clinical experience of some therapists. Although the vast majority of clients believe therapists should keep careful records, it is unclear if they appreciate some of the possible risks involved, such as the stigmatization that can occur because a person undergoes psychiatric treatment (e.g., the problems that Senator Thomas Eagleton encountered when he was named a Vice Presidential candidate and his psychiatric history later became known). Interestingly, the views of actual clients are often reasonably similar to those of nonclient subjects in analog studies, such as college students (Meyer & Smith, 1977).

Effect of Demographic and Other Factors

As noted previously, demographic factors were mildly predictive of attitudes toward confidentiality. Consistent with the results of most previous studies (Lindenthal & Thomas, 1980; Rosen, 1977; Woods, 1977/1978; but not Simmons, 1968), females tended to be more concerned about confidentiality. However, they only had higher scores (showing more support of confidentiality) on 4 of the 20 Likert

scale items and were more deterred by a lack of confdentiality in seeking treatment. The reasons the differences were fairly limited are unclear. As predicted, and as found in another study (Rosen, 1976a, 1976b), better educated clients were slightly more concerned about confidentiality. Age was inversely correlated with concern about confidentiality and Whites were more concerned than Non-whites with confidentiality.

Marital status, occupational prestige, and some factors related to treatment (such as referral source and previous treatment) were not consistently correlated with views on confidentiality. However, consistent with C. E. Rosen's (1978a, 1978b) view that contextual factors influence confidentiality related behavior, factors related to previous confidentiality experiences did affect overall views. For example, clients who had been in a situation where confidentiality was broken were more concerned about it, which is consistent with a report on professionals (Lindenthal & Thomas, 1980).

Review of Hypotheses

While the previous discussion has addressed the key issues and findings of the study, it would be desirable to briefly summarize the results in terms of the specific experimental hypotheses outlined in Chapter 2.

The following experiemental hypotheses were confirmed: Females tended to be more concerned about confidentiality than males, age was inversely correlated with concern about confidentiality, educational level was directly correlated with preference for confidentiality, factors

related to treatment were somewhat related to attitudes on confidentiality, clients coming to a center for the first time were a bit more concerned about confidentiality than those who had come previously, previous experiences with confidentiality were strongly related to views on this topic, a significant number of clients reported hesitation in seeking help because of concerns about confidentiality, a significant number of clients reported having been in a situation where confidentiality had been violated, lack of confidentiality definitely is a deterrent in clients seeking help, and clients whose confidentiality had previously been violated were much more concerned about confidentiality.

As predicted, clients favored breach of confidentiality in the following circumstances: prevention of suicide, notification of employers of impaired clients holding sensitive jobs, prevention of child abuse and neglect, prevention of serious harm to another person, consultation with professional colleagues, and preservation of public safety in some specific cases. Despite sanctioning these breaches, many clients also preferred confidentiality to be absolute.

Also as predicted, clients wanted access to records kept on them, strongly felt confidentiality was relevant and important in seeking help, routinely expected confidentiality, strongly believed therapists have an obligation to maintain confidentiality, felt that records should be kept, stated they were concerned about confidentiality, very much wanted to be informed about any limits on confidentiality, and expressed a strong preference for confidentiality. Despite this, their positions varied with the context. While agreeing with professionals

that confidentiality is important, many clients expressed preferences incongruent with common practices related to confidentiality.

Contrary to what had been expected, Non-Whites were not more concerned about confidentiality, occupational prestige was often negatively correlated with concern about confidentiality, clients coming for help voluntarily tended to be more concerned about confidentiality than those coming involuntarily, many clients reported using caregivers other than mental health professionals out of concern over confidentiality, and clients tended to be unconcerned about incidental loss of privacy when coming for treatment. Clients also did not favor therapists breaking confidentiality under court order and the parents of teenagers being notified when the teenager sought treatment. Clients opposed personally identifying information being sent to a central registry, an important aspect of maintaining fiscal and administrative accountability.

The data were unclear or mixed regarding the following hypotheses: the relationship between marital status and concern about confidentiality, the effect of previous treatment on attitudes, and whether or not self-referred clients were more or less concerned about confidentiality. Clients slightly favored breaking confidentiality to apprehend intoxicated drivers and thus preserve traffic safety, but also slightly opposed breaking confidentiality to apprehend criminals.

Suggestions for Further Research

Perhaps the most relevant extension of the study would be the development of a more homogeneous scale to assess overall attitude

toward confidentiality. Here it was difficult to create a composite score, which could summarize concern about confidentiality, because of the heterogeneity of the items. One alternative would be to only combine into a composite measure those items that are most related to the main theme of circumstances justifying breach of confidentiality (e.g., leaving out Likert scale items 3, 9, 10, 11, 17, and 18). Another alternative would be to create a composite measure based on factor scores of the existing items.

The basic methodology of this study could easily be extended to a wider range of clients, for example, those in different geographic (e.g., urban), treatment, or institutional settings (such as the military). It might be good to follow up on several inconclusive findings, such as the limited gender effect and difference between voluntary and forced referral clients. The influence of other factors, such as diagnosis and personality characteristics, could be investigated. It would be particularly interesting to look at the unexpectedly high incidence of use of ministers for help with personal problems, hesitance to seek treatment out of concern over confidentiality, and reported breaches by therapists (e.g., what types of therapists break confidentiality and under what circumstances).

It is ironic that perhaps the clients most at risk of having their rights violated (e.g., minors, those severely disturbed, and the developmentally disabled) had to be excluded from the study. Although it would be difficult to assess their views, this might be of real value. The attitudes of children, adolescents, and their parents are of particular interest (e.g., given the popularity of family therapy

and the ethical dilemmas peculiar to working with adolescents).

While the attitude scale that was developed proved reliable, would it be sensitive enough to measure the hypothesized changes in clients' attitudes during the course of treatment? This is a significant question that merits attention. For example, it seems that as clients stay in therapy trust develops and more productive therapeutic work is done; although more sensitive issues are dealt with, clients seem less concerned about privacy, perhaps as their emotional health improves and they become more self-accepting. Once treatment is over, clients often become more open about their previous problems and sometimes end up referring friends (if their therapy was a positive experience). In some ways, one would expect the most concern about confidentiality at the start of treatment; that is one reason intake procedures are felt to be so critical. In connection with clients informing others about their problems and treatment, it may very well be that they themselves divulge more than therapists ever would. It would be interesting to examine what clients tell significant others about themselves, their problems, and what happens in treatment.

As one research participant suggested, it would be desirable to administer the questionnaire to mental health workers, to see what their attitudes are and how they compare with those of clients. The attitudes and expectations of other caregivers and community agencies could also be examined (e.g., they may have needs that therapists and clients may want to address). It would be interesting to more closely evaluate the views of clients in situations where confidentiality and/or the allegiance of the therapist would be expected to be a problem.

For example, the views of clients court ordered for treatment, such as those arrested for drunk driving or reported for child abuse, would be of real interest.

In addition to exploring attitudes, it would be very desirable to look at actual confidentiality related behaviors of clients. In particular, it would be good to repeat the studies of Meyer and Willage, and Woods using actual clients as subjects. It is expected that confidentiality conditions would have an effect on self-disclosure and perhaps even on treatment outcome itself. Knowledge about, and attitudes toward, confidentiality could be related to such things as premature termination in treatment and choice or avoidance of certain types of therapists or therapies. The effects of informed consent and access to records should be evaluated using an outpatient sample, something which apparently has not yet been done.

Implications

Overall, clients favor confidentiality; on this, they are in agreement with the majority of professionals (American Psychiatric Association, Task Force on Confidentiality, 1975; American Psychological Association, Task Force on Privacy, 1977; Beigler, 1981a, 1981b; Blomquist, 1977; Daley, 1975; De Marneffe, 1976; Everstine et al., 1980; Freedman, A. M., 1979; Grossman, 1977; Group for the Advancement of Psychiatry, 1960; Hollender, 1960, 1965; National Institute of Mental Health, 1981; Noll & Rosen, 1982; Redlich & Mollica, 1976; Reynolds, 1976, 1977; Robitscher, 1980; Siegel, 1976, 1979; Spingarn, 1975; Stone, 1976b; Wilson, S. J., 1978; Wise, 1978).

On the other hand, clients, like many professionals, do not seem particularly knowledgeable about relevant policies and laws. Greater efforts to educate clients (e.g., through the development and routine distribution of information materials) may be desirable, particularly in view of their expressed interest in knowing more about these matters (as seen in their written comments, presented in Appendix G). That potential clients may be deterred from seeking treatment by fears about confidentaility, suggests the need for public relations efforts to inform them of their rights and the protection they have.

Given the stress that clients place on confidentiality, therapists may want to more closely examine some routine practices that compromise patient privacy and perhaps make changes in them. For example, the necessity of sending personally identifiable data to a central registry might be re-evaluated. Various simple procedures could materially improve confidentiality. For instance, informed consent procedures could be instituted to provide clients relevant information regarding treatment and their rights. As C. E. Rosen's studies have demonstrated, simply informing clients of their rights can result in those rights being asserted more frequently.

To help professionals be sensitive to ethical issues, more educational efforts are indicated. Graduate school courses, workshops for practitioners, and agency inservice training could all help inform and sensitize therapists. There may be inherent conflicts of interest for therapists (particularly, in institutional practice); these need to be recognized, discussed, and researched. As these issues are publicized and professionals clarify their own positions, clients

may be in a better position to choose those therapists whose views coincide with their's (e.g., thus reducing the possibility of misunderstandings and violations of strongly held beliefs and preferences). Clients thus could express their views by concrete action, and competitive, free-market forces could influence what professionals do. Interestingly, Lindenthal and Thomas (1980) predict that clients may someday choose therapists on the basis of their ethical stances.

Here, as in other studies, an issue that emerges again and again is the seemingly inherent conflict among competing values and interests. In particular, preservation of confidentiality may run counter to other highly valued social norms, such as protecting innocent persons from harm and furthering the welfare of society, even if this may conflict with the needs of the individual. The therapist is usually called upon to function in many different roles: helper to the client, reporter of child abuse, agent of the court, employee of an agency, etc. These roles may be conflicting and certainly confusing, to the therapist and likely even more so to his or her client. What is often "called the 'double agent problem' is really a problem of multiple agency, of conflicting responsibilities and confused loyalties, of undefined purposes and contradictory goals." ("In the service," 1978, p. 2).

This tension is apparent in terms of the clients' responses to the test items and their written comments. Specifically, while most clients wanted confidentiality to be absolute (which would be for the good of the client and presumably lead to more successful

therapy), they also recognized that the vital interests of others merited some protection and felt confidentiality should be broken in some limited cases. Their comments and questions indicate real concern about these issues. In general, it seems that clients want the therapist's primary allegiance to be to the client, although they recognize this may not always be possible. They do not seem to welcome the therapist as an agent of social control.

It appears that the therapist is inherently an agent of society, and some of this seems to be for the better. For example, clients usually enter therapy for the relief of some type of distress, dysfunction, or symptom. Social norms favor individuals seeking relief from distress, improved functioning, and alleviation of symptoms. In helping the client in these ways, the therapist functions as a positive agent. Society also allows professions to exist, supports them, and regulates their operation. When the client's needs and desires coincide with those of society, the professional's role is much clearer and he or she can function as an agent of both.

The fundamental question appears to be what (social) values should be held by the therapist and how should they be transmitted to the client? A therapist cannot be free of values. Some social values appear to be good ones (e.g., personal responsibility, autonomy, freedom from distress, altruism) while others appear less positive (such as conformity and materialism). There also are ethical differences based on how these values are expressed in a therapeutic relationship. For example, contractual psychotherapy

based upon the client's fully informed consent seems more desirable than forced treatment based upon deception or lack of knowledge.

The question for the therapist is not whether to be or not to be an agent of social control, but how to do so and to what extent. It is critical that clients know this function of the therapist and that the therapist be explicit about his or her values. As suggested earlier, perhaps clients can eventually choose therapists on the basis of mutual values and goals. The only way this can happen is if the values of both groups are made known. This study has been an attempt in that direction.

In conclusion, to the extent that these theoretical issues and ethical positions can be translated into empirical terms and systematically investigated, the understanding and protection of patient rights will advance. If clients are to be fully served, then ethics must be actualized in theory, practice, and research. However, while this process might yield valuable information, it is unlikely to fundamentally alter the moral dilemmas involved. As important as preservation of clients' rights is, "in the end, in this as in most other things, patients must depend on the moral character of those entrusted to treat them" (Stone, 1976a, p.1141). And that responsibility, and its maintenance, is a perennial human concern.

APPENDICES

APPENDIX A

POOL OF HIGHLY RELEVANT ITEMS

Pool of 72 Highly Relevant Items

Circumstances Under Which Confidentiality Should be Broken

1. Any, as long as the client is not harmed.
2. Better enable a spouse or family member help the client (by providing them relevant prognostic and diagnostic information along with treatment recommendations).
3. Prevent a serious crime (by notifying the proper authorities).
4. None, confidentiality should be absolute.
5. So the referral source knows the client came for help.
6. Prevent suicide (by informing the appropriate individuals or agencies so precautions can be taken).
7. Prevent homicide or serious bodily harm to someone else (by notifying the proper authorities).
8. Apprehend a drug abuser.
9. Apprehend a person who has committed a serious crime.
10. Help a physician better care for the health of his/her patient.
11. Under court order.
12. Assist parents in taking care of the needs of their minor child.
13. Deal with child abuse (i.e., reporting it so the victim can be protected and the abuser receive treatment).
14. Consult with another professional (e.g., to get the benefit of his/her experience in understanding the case and formulating better treatment plans).
15. Consult with another agency.
16. Obtain insurance reimbursement for treatment expenses.
17. Commitment.

18. Help the client's attorney better represent the legal interests of his/her client.

19. Help the client's minister/priest/rabbi deal with the client's spiritual needs.

20. Protect national security (e.g., by reporting disloyal individuals and spies).

21. Supervise the therapist (e.g., through discussion of the case, observation of therapy sessions, audio or video recording of sessions for later analysis, etc.).

22. Audit the financial records of the agency (e.g., by letting auditors examine client records or even contact clients to verify billings).

23. Help the state government keep track of clients, problems being experienced, and services provided (by providing information to a central registry).

24. Support quality assurance efforts.

25. Warn the intended victim of a crime a client plans to commit.

26. Case staffing.

27. Help law enforcement personnel enforce the laws by disclosing any illegal acts.

28. Provide information to a third party which is paying for treatment.

29. So an employer or potential employer could know if a client were suitable to perform a certain job.

30. Prevent drunk driving.

31. So an agency could be run more efficiently.

32. So an agency could provide higher quality service (e.g., through staff training, supervision, quality assurance efforts, etc.).

33. Maintain traffic safety by making sure only healthy people can have driver's licenses.

34. Maintain aviation safety by making sure only healty persons obtain and maintain pilot's licenses.

35. So only financially responsible persons obtain credit.

36. Coordinate and deliver social/human services (e.g., through active interagency contacts, casefinding, etc.).

37. Make sure only emotionally stable individuals obtain and hold sensitive positions (such as physician, high governmental official, military personnel who work with nuclear weapons, etc.).

38. Screen out emotionally disturbed applicants who want to enter professions (by applying to graduate or professional schools).

39. Only to save a life.

40. Help another therapist working with the client later on.

41. Make sure only emotionally stable people maintain their parental rights.

42. Reduce insurance fraud (by exposing patients and health service providers who are involved in fraudulent claims).

43. Conduct legitimate scientific research.

44. Train students in mental health professions (e.g. by live or taped demonstrations of contacts with clients).

45. Help whoever might be working with a client (e.g., paraprofessional, lay support group, etc.).

Other Aspects of Confidentiality

1. A client would feel betrayed if a therapist violated confidentiality.

2. It is important that clients feel free to say anything to a therapist without worry that it may be disclosed to others.

3. Clients should be informed about limits on confidentiality.

4. A client should be able to see his/her case file.

5. Most clients expect that communications with mental health professionals will remain confidential.

6. Confidentiality is essential in maintaining a positive therapeutic relationship.

7. A therapist has a professional/ethical obligation to keep information regarding a client confidential.

8. Clients hesitate to consult mental health professionals because of concerns about confidentiality.

9. Clients report they have had confidentiality broken by a therapist.

10. Without confidentiality, clients would limit what they disclosed in therapy.

11. Clients assume confidentiality is absolute.

12. Confidentiality is essential for effective treatment of emotional problems.

13. Clients are concerned about confidentiality.

14. If a client had to choose between complete confidentiality and getting help for his/her problems, the latter would be chosen.

15. Clients go to ministers/priests/rabbis for help with personal problems because of the absolute confidentiality in such relationships.

16. A therapist should withhold information from a client if he/she believes it might harm the client.

17. Clients expect therapists to obey court orders and reveal confidential information.

18. Careful records should be kept on clients and the services they receive (even if this might compromise privacy).

19. Records of treatment should be kept indefinitely.

20. Clients are concerned about professionals maintaining confidentiality.

21. Clients are concerned about nonprofessionals, such as agency clerical staff, maintaining confidentiality.

22. Clients are concerned about loss of privacy in waiting rooms and other situations when they seek help.

23. Confidentiality is fairly important to clients in comparison with other values or needs.

24. Clients expect therapists to break confidentiality only to protect their life or that of another person.

25. Clients would like confidentiality to be absolute.

26. Clients are aware of breaches of confidentiality by therapists.

27. Clients want to be informed if a therapist breaks confidentiality even if they don't have the chance to consent or refuse to do so.

APPENDIX B

QUESTIONNAIRE

Please read each of the following statements and say how you feel about it. Circle the one word that best describes your opinion. There are no right or wrong answers; your feelings are the only things that count. Try to answer every item.

1. A client should not be able to see what's in the file that a therapist (counselor) might keep on him or her.

   strongly agree | agree | neutral | disagree | strongly disagree

2. If a judge orders a therapist to tell about his/her client, the therapist should refuse because it's confidential (private or secret).

   strongly agree | agree | neutral | disagree | strongly disagree

3. If a therapist is to really help a client, the client must feel free to talk about anything and not have to worry that the therapist would tell anyone else (about what the client said).

   strongly agree | agree | neutral | disagree | strongly disagree

4. To protect national security, a therapist should inform the authorities about a client who is a security risk (for example, a spy).

   strongly agree | agree | neutral | disagree | strongly disagree

5. If a teenager talks with a therapist about some problems, the therapist should be able to tell his/her parents without the client's permission.

   strongly agree | agree | neutral | disagree | strongly disagree

6. To prevent a client from killing or seriously hurting themselves, a therapist can tell someone else about this (even if the client doesn't want him/her to say anything).

   strongly agree | agree | neutral | disagree | strongly disagree

7. An agency should give information about clients (such as their name, address, and what kind of problems they have) to the State so it can keep track of who gets help, what types of problems people have, and how much money is spent helping people.

   strongly agree | agree | neutral | disagree | strongly disagree

8. For traffic safety, a therapist should tell the police if one of his/her clients is drunk driving.

strongly agree | agree | neutral | disagree | strongly disagree

9. A client naturally assumes that what he/she tells his/her therapist is completely confidential (that is, completely private or secret).

strongly agree | agree | neutral | disagree | strongly disagree

10. I'd rather nobody knew I came here. For example, I hope no one I know sees me in the parking lot or waiting room.

strongly agree | agree | neutral | disagree | strongly disagree

11. A therapist has a professional obligation (or duty) to keep information about a client confidential.

strongly agree | agree | neutral | disagree | strongly disagree

12. Confidentiality should be absolute: a therapist should never tell anyone anything about a client without the client's permission.

strongly agree | agree | neutral | disagree | strongly disagree

13. A therapist should keep careful records about a client and his/her problems (so the therapist can better help the client).

strongly agree | agree | neutral | disagree | strongly disagree

14. A therapist should inform the police or welfare authorities if a client tells him/her that they are abusing or neglecting their child.

strongly agree | agree | neutral | disagree | strongly disagree

15. If a client has a very sensitive job and might hurt someone because he/she can't handle it, the therapist should tell the client's employer. (Examples of sensitive jobs would be airline pilot, physician, and soldier who works with nuclear weapons.)

strongly agree | agree | neutral | disagree | strongly disagree

16. Even if a client admits committing a serious crime, his/her therapist should not tell the police because what the client said is confidential.

strongly agree	agree	neutral	disagree	strongly disagree

17. I would like what happens here to remain confidential.

strongly agree	agree	neutral	disagree	strongly disagree

18. If there is anything a therapist might have to tell others about a client (without his/her permission), the client should be told about this.

strongly agree	agree	neutral	disagree	strongly disagree

19. Even if a client threatens to seriously hurt or kill someone, a therapist shouldn't tell anyone about it (because everything the client says should be kept private).

strongly agree	agree	neutral	disagree	strongly disagree

20. A therapist should talk with other therapists (where he/she works) to get ideas on how to better help a client with their problems.

strongly agree	agree	neutral	disagree	strongly disagree

To help us understand your views better, could you please answer the following questions about yourself? Remember this is completely anonymous; do not give your name.

1. What is your gender? Check one: Female _____ Male _____.

2. How old are you? _____ years.

3. How many years of school have you finished? _____ years.

4. What is your race? Check one:

Black _____ Oriental _____
Hispanic _____ White _____
Native American (Indian) _____.

5. What is your marital status? Check one:

Divorced _____ Single _____
Married _____ Widowed _____
Separated _____.

6. What is your occupation (for example, farmer, homemaker, teacher)?

_____.

7. Have you ever been here before? Check one: Yes _____ No _____.

8. Have you ever been to another Human Service Center, mental health center, psychiatric unit, alcohol or drug treatment program, or therapist? Check one: Yes _____ No _____.

9. Who referred or asked you to come here? Check only one:

Employer _____	Physician _____
Family member or friend _____	Police or court _____
Hospital _____	No one, I came by myself _____
Minister/priest/rabbi _____	Other (please specify) _____.

10. Are you coming here voluntarily, or is someone making you come? Check one: I'm coming here because I want to _____ I'm coming here because I have to (that is, someone is forcing me to come) _____.

11. Have you ever gone to a minister/priest/rabbi for help with personal problems <u>because</u> you knew whatever you said would be kept absolutely secret? Check one: Yes _____ No _____.

12. Have you ever hesitated to see a therapist because you weren't sure that it would remain confidential? Check one: Yes _____ No _____.

13. Have you ever been in a situation where a therapist has told other people things that you expected him/her to keep secret? Check one: Yes _____ No _____.

14. If a therapist told you that what you discussed would not be considered confidential, would you (Check the <u>one</u> statement that best describes your feelings):

_____ a) Decide not to see the therapist?
_____ b) See the therapist but be less open in what you talked about?
_____ c) See the therapist but with no difference in what you talked about?
_____ d) Keep seeing the therapist and be more open?

15. What is today's date? Month _____ Date _____ Year _____.

16. So we can better understand <u>your</u> views on the topic of confidentiality, please write down any comments or questions you might have.

You are now finished with the questionnaire. If you would like a copy of the results, put your name and address on the attached card and hand it in separately; they will be mailed to you in a few months. Now please put the questionnaire in the envelope, seal it up, and return it (as described on the first page). Thank you again for your cooperation.

APPENDIX C

SAMPLE COVER LETTER

NORTH CENTRAL HUMAN SERVICE CENTER
400 22nd Avenue Northwest, Minot, ND 58701
(701) 852-1251

October 21, 1982

Dear Client,

I would like to ask you to take part in a short but important research project. It involves filling out the attached questionnaire and should only take about 5 minutes. Let me give you some more information so you can make a decision about participating.

The purpose of this study is to find out clients' views on confidentiality and other matters at Human Service Centers. We will be asking your opinions on a variety of hypothetical (or made up) situations; these are not related to the actual policies or procedures at this Agency.

Filling out this questionnaire is completely voluntary and will have no effect whatsoever on any service you might receive from the Center. In fact, no one here will know what you said: it is completely anonymous.

Although you might not directly benefit from the study, it will give you a chance to let us know how you feel about some important matters. You can help us learn more about what clients think; this will help others now and in the future. The risks of the study are minimal.

If you have any questions about these issues or actual Center policies, please discuss them, like you would any others, with the staff member you are seeing. Any questions or concerns about the research project itself should be directed to me.

Should you have any questions at this point, please ask the person who gave you this for more information. If you go ahead, please remember that you have the right to not answer any question and to stop at anytime. Do not fill out the questionnaire if you are less than 18 years old. By going ahead, you indicate that you have received this information, understand it, and agree to participate in the study.

When you finish the questionnaire, seal it up in the attached envelope and return it to the person who gave it to you. If for some reason you haven't completed it by the time of your appointment, please take a few minutes afterward. If you have to leave, return it the next time you come in or mail it in the envelope. If you mail it and give your return address, your postage will be refunded.

Thank you for your help.

Steve Podrygula
Psychologist II

APPENDIX D

SAMPLE LETTER TO COLLEAGUES

NORTH CENTRAL HUMAN SERVICE CENTER
400 22nd Avenue Northwest, Minot, ND 58701
(701) 852-1251

October 24, 1982

Dear Colleague,

The purpose of this letter is to provide you background information regarding a research project that will shortly be conducted at the Center. As a courtesy, I wanted you to be aware of this even though you would not be directly involved (although one of your clients might comment on it or ask you a question). Needless to say, the Agency's participation has been approved by the Director.

The topic of this study is client attitudes on confidentiality and other matters at Human Service Centers. For a period of about a month, all new clients at the Agency (with certain exceptions, such as those in acute distress or developmentally disabled) will be given a short questionnaire to fill out; current active clients will not be surveyed. It is self-administered; the receptionist will hand it out as the client first comes in.

By the time the client sees you, it is expected that he or she will have filled out the form and turned it back in at the reception desk. If the client hasn't finished, then they have been asked to complete it after the appointment. To maintain objectivity, please do not give any substantive advice or assistance (regarding the form) to any client who has not filled it out and handed it in.

Participation in the study is completely voluntary and the responses are totally anonymous. The procedures and questionnaire have been thoroughly pretested; the risks are felt to be minimal and the potential benefits significant. About the worst that might happen is that a rare client might become irritated by answering the questions.

On the other hand, it is possible that some clients may become more sensitive to confidentiality or the other topics covered in the study. They may express some concerns to you or ask you questions. If this should occur, I recommend dealing with it as you normally would: for example, listening to their concerns, providing reassurance, and explaining relevant Center policies and procedures.

If you are interested in further information on this study, please contact me. Once it is completed, a copy of the results will be made available to you and mailed to each client that requests them. I appreciate your cooperation in this project and look forward to the results benefiting all of our clients.

Steve Podrygula
Psychologist II

APPENDIX E

SAMPLE INSTRUCTIONS FOR SUPPORT STAFF

RESEARCH PROJECT

Instructions for Support Staff

1. Give a copy of the questionnaire to each new client, first admission or re-admission, but not to clients that are already coming to the Center (i.e., those with open cases).

2. Hand out the form when the client first comes in, before he/she sees anyone else.

3. Ask them to participate in the study once you've greeted them, and gotten their name and who they've come to see. For example, you might say "could you fill out this questionnaire?"

4. Do not give the form to the following types of clients:

    a) Those in acute distress: for example, clients who are crying, very upset, really angry, severely depressed, etc.
    b) Clients who are out of touch with reality: those who are intoxicated or psychotic.
    c) Those who cannot easily understand you. Examples would be developmentally disabled clients, those who cannot speak English well, and those who cannot read or write.
    d) Clients with handicaps that prevent them from reading or writing easily: for example, blindness, paralysis, etc.
    e) Those under the age of 18 or those that have been declared legally incompetent.

5. If a client has any significant questions, give them a copy of the research project information sheet. If they still have questions, take back the questionnaire and thank them for their interest, but do not let them go on (as they probably couldn't or wouldn't answer the questions appropriately). Refer them to their therapist if they have any concerns about actual agency policies or procedures. Direct them to me if they have any questions or concerns about the project itself.

6. If any client does not want to participate, do not encourage them or insist that they do so. It is completely voluntary.

7. If you have any questions or problems, discuss them with me.

Thank you for your help.

APPENDIX F

RESEARCH PROJECT INFORMATION SHEET

Research Project Information
Some Questions and Answers

1. Q. Why are you doing this research?
   A. We are interested in clients' views on confidentiality and other topics. Although some research has been done on the views of professionals, very little is known about what clients think about these things. We feel that clients' views are important, that is why this research is being done.

2. Q. Why do you want my opinions?
   A. We are asking a large number of clients for their opinions. You have been asked to fill out the questionnaire only because you have come here. For a period of time nearly every new client at the Center will be asked to participate in the study. Your opinions are important to us, that is why we would like them.

3. Q. Do I have to take part in this study? What happens if I don't want to answer the questions?
   A. Whether or not you participate in the study is completely up to you: it is purely voluntary and will have no effect on any services you might receive from the Center. Remember it is completely anonymous: we do not want to know your name and have no way of knowing who said what. If you don't want to participate, just give the questionnaire back to the person who gave it to you. Even if you do participate, you don't have to answer any question if you don't want to.

4. Q. What does "confidentiality" mean?
   A. Confidentiality refers to the duty a professional has to keep information about a client secret and not let anyone else know about it (unless they have a right to). Something that's confidential is private or secret.

5. Q. Is this study confidential?
   A. It is not confidential, but the questionnaire is completely anonymous: no one will know what a particular person said. There is no way you could be identified from your answers. When the results are put together, we will be interested in the responses of groups of people, not any one individual. The study cannot be confidential because the overall results are meant to be shared with other professionals interested in this subject. It is anonymous so that you can feel free to say whatever you wish and not have any worries about taking part.

6. Q. Why do you want to know my age, race, etc.?
   A. We need to know a little bit about you so we can understand your opinions better. The results will mean a lot more if we know what different types of people think; we are not interested in any one particular person's answers. Remember you don't have to answer a given question if you don't want to.

7. Q. What should I do if I don't understand the questionnaire?
   A. If you have any problems understanding this, please do not fill out the questionnaire: return it to the person who gave it to you.

8. Q. Can I get the results of the study? If so, when and how?
   A. You can get a copy of the results by writing your name and address on the little card attached to the questionnaire and handing it in. Once the study is done, which should be within a few months, you will be mailed a copy of the results.

9. Q. What happens after I fill out the questionnaire?
   A. When you are finished, return it to the person listed on the first page. If you prefer, you can mail it in; if you give your return address it will be kept confidential and your postage will be refunded. Filling out the form is all that you have to do. Once enough questionnaires are completed, they will be sent back to the researcher who will put all of them together and find out the results. A report will then be written to share the results with others interested in this subject.

10. Q. What should I do if I'm under 18 years of age?
    A. If you are under 18, please do not fill out the questionnaire: return it to the person who gave it to you. At this time, we are only looking at the views of adults.

11. Q. Are there any risks in taking part in the study?
    A. The risks, if any, are very small. About the worst that might happen is that a person who does not like filling out forms might get a little irritated by being asked to do so. But remember that no one has to participate in the study if they don't want to. It is also possible that a client might become concerned about some of the topics brought up in the questionnaire. If this should happen, the client should talk about their concerns with the staff member they came to see. The important benefits are felt to be much more significant than the minimal risks.

12. Q. What are the advantages of participating in the study?
    A. Although you might not directly benefit from the study, your participation should help us learn more about what clients feel regarding some important topics. This will help advance knowledge and should lead to policies and procedures that better meet clients' needs. The more sensitive clients and professionals are to these issues, the better off everyone will be.

13. Q. If I have a question about my coming here, who should I ask?
    A. If taking part in this study has raised any questions or concerns, please talk about them with the staff member you came to see.

14. Q. If I have some other questions about this study, who should I ask?
    A. The name of the person who should be able to answer your questions is in the letter on the first page of the questionnaire. You can also directly contact the researcher if you would like.

APPENDIX G

RESEARCH PARTICIPANTS' COMMENTS

WRITTEN COMMENTS

This appendix presents, verbatim, the written responses of the research participants to the following questionnaire item: "So we can better understand your views on the topic of confidentiality, please write down any comments or questions you might have." The numbers are the identification number of each completed questionnaire. Responses 0005 through 0028 are from NCHSC, 0037 through 0146 from NWHSC, 0162 through 0250 from SEHSC, 0255 through 0357 from WCHSC, 0359 through 0383 from LRHSC, 0390 through 0427 from SCHSC, and 0434 through 0464 from NEHSC.

0005. I believe if ones does harm to one self or to others it shouldn't be confidential.

0014. I think if it's confidential the client will open up more

0019. Some of the questions have both yes and no answers. #11 for example, half is yes, half is no!

0020. I appreciate confidentiality, but as some of the above questions extenuiting circumstances might call for a breech of confidentiality.

0022. A theripist should be here to help people to the best of his ability and to help help them solve and reach their problems in a short time.

0028. I think it would be extremely difficult generally to make rules on confidentiality. Each individual case should be considered.

0037. Some of the questions asked I feel the decision should be lef to the therapist as to the protection of harm to self or others.

0049. When a session begins, confidentialness should be brought out & made clear ear.

0051. I filled this questionnaire out with my own problems in mind.

0057. People talk more openly with things they talk about are kept confidential.

0061. Confidential is one thing--but if the person on pre-ceeding

pages want to hurt someone or planning to kill--someone should be notified.

0066. A therapist should totally assure his/her client that whatever is discussed should be kept confidential.

0068. I belive in the question of confidentiality there always remains two questions (continued on back page)

Question #1--In order to remain an active therapist how much of ones own ethics would be jeoporized in positive confidentiality as well as how much of the therapists own personality must be sacrificed for the sake of the patient. My view: Confidentiality should be assumed and provided in a therapist-patient relationship only in the respect that professional ethics on a humane level aren't jeopardized or present laws are not being, broken by the confidential relationship.

Question 2 and my view: If knowledge is in light that laws are being broken, who should remain respornsiblety for the sentence of such law if not reported.

I feel that knowledgeable breaking of the law should be reported and that the only respect one may show, for themselves as a patient or therapist is the inner knowledge that once payment has been many in any form for the law-breaking the law-breaker has paid the price and not feel quilty about anything.

0075. I remained neutral on many points involving the therapist because these questions have many other circumstances that must also be considered. for the most part I would agree but not always.

0083. If a therapist thinks he can help by not being confidential, I feel its okay.

0084. I have and open oppion and am nutral

0090. I am not really shorer

0091. I feel it should be allowed to disclose info--like to a judge--<u>only</u> if it done in complele confidentiality and not in front of a whole courtroom, etc.

0093. In order to fully help a client, sometimes some problems must be exposed in order to make that client understand his/her character

0104. Therapist should remain confidential unless it is harmfull to others

0110. Believe I've answered the above enough

0111. Confidentility is hard to answer to as I went through it I could see some exception to first thought

0112. Confidentiality has its limits. When harm has occured or is going to occur then someone should be told.

0117. I have no idea what the laws are on some of these questions.

0122. Basically, confidentiality to me means not discussing the problems of the client outside of a professional setting such as in public, at home, etc.

0124. This questionaire has raised my curiosity re: confidentiality and putting me on guard immediately

0136. Confidentualality is a must unless it will seriosly injured someone

0137. The descussions should be kept confidential except if it ment harming another person.

0138. Should be kept from other people

0145. Strongly believe confidentiality should be absolute. But admit to so me confusion conserning same Question no. 12--should have bee asked last

0146. I admit that in some extreme cases there can be no absolutes--in all general I am for strong confidentiality.

0162. So of the questions have to do with moral obligations of theripist and are open to some variance even in my mind

0167. I think its OK to tell the information but don't use the name if a person wants to discuss it with co-workers. I suspect people with case loads get callous about the privacy of the clients

0172. Confidentiality should be a general policy broken only at the discrestion of the councilor to protect the patient or the deffensless

0189. I think this is a really nice service to have for people who can't affort to pay alot of money!

0190. Some questions were hard to answer, because it depends on the circumstances of each case.

0197. You can still find out who did this questionnaire by comparing the application of services figures and date to this.

0198. If my parents come in for couseling will they be told everything I said?

0201. I have come here to get counseling with the hope that what we discuss will be between her & I.

0215. I am unsure about #6 and #19. Regarding #20, the therapist should already be knowledgable w/o asking associates.

0219. I circled "neutral" when there was no applicable answer, or an answer which required extensive explanation.

0229. My answers are based on the premise that therapist, client meeting is confidential unless client or other peoples might be injurged

0233. If the client talks about himself than thing should confidentail But if He talks about somebody eles thats different.

0236. I feel if the information has to be shared with someone else to help another person, it should be shared.

0240. If confidentiality where broke it would depend on to who and what situations.

0246. The only things that shouldn't be confidental is if the client is going to, or is hurting someone else with his/her own problems.

0247. I do believe in confidentiality. However, if the person in therapy shows signs of killing themself or someone I truly belive the therapist must take extreme measures by telling the proper people or who ever can help.

0250. Some of you questions are very abstract.

0255. I believe everything should be kept confidential between the therapist & patient--as long as it is <u>not</u> endangering the life of others.

0262. I felt it was hard to answer this questionaire because there is always an exception to the rule especially when it comes down to hurting one self or someone else.

0270. I answered nutral to some because of situations and people differ.

0279. I think whats confidential should be absolutely secret unless inury or death is involved

0282. Confidentiality is of upmost importance. However, if someone's life is in danger help should be sought for all parties involved. You don't have to go public--only inform the proper parties.

0283. I feel in cases of national security, suicide, murder or circumstances involving life threatening situations there could be reason to disclose certain information.

0287. I think that without confidentiality this program would be out of business. I Belong to AA and NA and we have to keep it there or we cant help.

0289. I feel things should be kept confidential, except in cases where someone could be hurt or in cases that it could help the client in anyway

0292. If any sexual attraction to therapist develops--switch to another

0295. I think confidentiality is very important--but there has to be exceptions to complete confidentiality in certain instances, such as the possibility of endangerment or harm of a human life.

0306. This is a very touchy subject because every situation is different an who is to decide what is right in every situation.

0307. Confidentiality is important--but not absolute. When a greater interest in involved, it must be flexible.

0310. In case of national security or when someone else may be injured someone should be notified.

0314. Confidentiality should benifit one no injure in some cases confidentiality would do more harm then help ones problem

0317. I believe in confidentiality but not when a serious crime has been committed.

0324. I feel information should be kept confidential unless it comes to hurting someone.

0325. Lord help the therapist who breaks anonymity

0326. I beleive your questions are to general those cannot all be answered the same because all people are diffent with different views

0333. I think for the offense of minor in possition is not substantial grounds for making a person or persons come to these meetings.

0335. Without confidentiality the therapeutic process between therapist & counselor would be underminded.

0338. If you wanted to tell everyone information you gave to someone concerning personal problems you would tell them yourself, they don't have to

0353. My feelings and believes and sertain problems are mine and should be confidential. I tell you I'm going to hurt someone it should be taken care of one way or another.

0357. on the things of crime and abuse I feel the therapist job is to get the right help for these people.

0359. The dilemma of a client's right to and need for, "total" confidentiality versus the public right to safety from an extremely troubled client can only be restored by keeping the policy that is fairest to the majority of clients in not violating their privacy, and yet allowing to make individual exceptions to prevent harm to innocent, vulnerable people.

0360. I feel that every thing should remain confidential unless the therapist informs me that he would find it more helpful and effective in my treatment if he contacted other people whom he has obtained written permission to contact and whom I feel will keep everything confidential also.

0365. I feel what ever I tell my therapist is no one elses business unless it is to my benifit.

0366. Confidentiality is privacy kept between you and your client.

0369. Some of the questions regarding confidentiality are <u>difficult</u>--#'s 14-15-4-6--<u>especially</u> very difficult

0373. For National Security, or <u>preventing</u> suicide or murder, I beleive in breaking confidentiality.

0383. I expect it to be confidential

0390. Question 20--a therapist could talk with other therapist in a general sort of way--no name, date, etc.

0397. I have come to understand that any client-therapist relationship is confidential. On the other hand, I feel a therapist should would know when it is necessary or would benefit a client to break confidentiality.

0399. I want people to know about my problem that are going to understand and help me solve the problem

0402. Anything a client tells a therapist should be kept totally confidential unless it is possibly going to harm someone else to do do.

0406. Some of the question on confidentiality debeen on the type of problem and if should be keep private

0418. Confidentiality is important until the patient and therapist have a good relationship and understanding to each other!

0419. I feel your questions were well put. We must always remember life is to be treated with great trust in each other.

0423. I think these questions contradicted each other. When someone ils going to be hurt, then I think it is wise for the therapist to say something.

0424. Number 15 proves you think out patients are a step below other people.

0427. Though confidentiality is very important there are cases in which for the safety of others or the client themselves that a therapist has the right to share any <u>helpful</u> information

0434. The questions I circled I didn't answer because I felt they were to ambiguous and really depended on the situation.

0439. I expect that info. I divulge is confidential as far as names, specific info. etc goes, but I realize clients cases are often used by staff for case studies. But I trust that info. about me or my family is not brought up in regular conversations.

0442. Anything said should be kept confidential <u>except</u> criminal charges like wife, child abuse, etc. they should be reported to police & dealt with.

0448. Rather than contacting police or welfare, in the case of child abuse, client should first be referred to child abuse support groups or asked if the welfare could be contact for assistance.

0456. I used to date a psychologist, so I've been assuming that all therapist would as ethical as was he. I would tend to trust a professional judgments about confidentiality

0457. If there is a threat to the individual or someone else, something should or be done to stop any harm

0464. Like everything else, confidentiality should be tempered with common sense.

APPENDIX H

KEY TO COMPUTER OUTPUT

Key to the Variable Symbols Used in the Computer Output

Category	Variable Name	Variable Symbol
Identifying	Facility Code	Y3
	Month	Y20
	Date	Y21
	Year	Y22
	Day	Y23
	Comment	Y24
Test	Record Access	X1
	Court Order	X2
	Openness	X3
	National Security	X4
	Teenager	X5
	Suicide	X6
	Central Registry	X7
	Traffic Safety	X8
	Expectation	X9
	Privacy	X10
	Therapist Obligation	X11
	Absolute	X12
	Record Keeping	X13
	Child Abuse	X14
	Sensitive Job	X15
	Crime	X16
	Preference	X17
	Informed Consent	X18
	Tarasoff	X19
	Consultation	X20
	Composite Score	X31
	Intermediate Score	X32
Demographic	Gender	Y6
	Age	Y7
	Education	Y8
	Race	Y9
	Marital Status	Y10
	Occupation	Y11
	Occupational Prestige	Y32

Key to the Variable Symbols Used in the Computer Output (continued)

Category	Variable Name	Variable Symbol
Treatment	Admission Status	Y12
	Previous Treatment	Y13
	Referral Source	Y14
	Entry Status	Y15
	Prior Treatment	Y30
	Forced Referral	Y31
Confidentiality	Use of Minister	X16
	Hesitation	X17
	Breach	X18
	Deterrent	X19

APPENDIX I

DESCRIPTIVE STATISTICS

PROGRAM FOR ALL SUBFILES 03/23/83 PAGE 9

FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X1 RECORD ACCESS

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY AGREE	1.	21	4.5	4.5	4.5
AGREE	2.	59	12.7	12.7	17.2
NEUTRAL	3.	59	12.7	12.7	30.0
DISAGREE	4.	192	41.3	41.4	71.3
STRONGLY DISAGREE	5.	133	28.6	28.7	100.0
	9.	1	0.2	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	3.769	STD ERR	0.053	MEDIAN	3.984
MODE	4.000	STD DEV	1.131	VARIANCE	1.279
KURTOSIS	-0.159	SKEWNESS	-0.824	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 464 MISSING CASES 1

PROGRAM FOR ALL SUBFILES 03/23/83 PAGE 10

FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X2 COURT ORDER

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY DISAGREE	1.	13	2.8	2.8	2.8
DISAGREE	2.	65	14.0	14.1	16.9
NEUTRAL	3.	97	20.9	21.0	37.9
AGREE	4.	160	34.4	34.6	72.5
STRONGLY AGREE	5.	127	27.3	27.5	100.0
	9.	3	0.6	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	3.699	STD ERR	0.051	MEDIAN	3.850
MODE	4.000	STD DEV	1.101	VARIANCE	1.213
KURTOSIS	-0.600	SKEWNESS	-0.528	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 462 MISSING CASES 3

PROGRAM FOR ALL SUBFILES 03/23/83 PAGE 11

FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X3 OPENNESS

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY DISAGREE	1.	5	1.1	1.1	1.1
DISAGREE	2.	4	0.9	0.9	1.9
NEUTRAL	3.	15	3.2	3.2	5.2
AGREE	4.	155	33.3	33.3	38.5
STRONGLY AGREE	5.	286	61.5	61.5	100.0
	TOTAL	465	100.0	100.0	

MEAN	4.533	STD ERR	0.033	MEDIAN	4.687
MODE	5.000	STD DEV	0.704	VARIANCE	0.495
KURTOSIS	6.359	SKEWNESS	-2.076	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 465 MISSING CASES 0

PROGRAM FOR ALL SUBFILES 03/23/83 PAGE 12

FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X4 NATIONAL SECURITY

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY AGREE	1.	68	14.6	14.9	14.9
AGREE	2.	185	39.8	40.6	55.5
NEUTRAL	3.	114	24.5	25.0	80.5
DISAGREE	4.	59	12.7	12.9	93.4
STRONGLY DISAGREE	5.	30	6.5	6.6	100.0
	9.	9	1.9	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	2.557	STD ERR	0.051	MEDIAN	2.365
MODE	2.000	STD DEV	1.096	VARIANCE	1.201
KURTOSIS	-0.324	SKEWNESS	0.563	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 456 MISSING CASES 9

PROGRAM FOR ALL SUBFILES 03/23/83 PAGE 13

FILE CLIENT (CREATION DATE = 03/23/83)

SUBFILE NC NW SE WC LR SC NE

X5 TEENAGER

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY AGREE	1.	17	3.7	3.7	3.7
AGREE	2.	57	12.3	12.3	15.9
NEUTRAL	3.	57	12.3	12.3	28.2
DISAGREE	4.	204	43.9	44.0	72.2
STRONGLY DISAGREE	5.	129	27.7	27.8	100.0
	9.	1	0.2	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	3.800	STD ERR	0.051	MEDIAN	3.995
MODE	4.000	STD DEV	1.088	VARIANCE	1.184
KURTOSIS	-0.003	SKEWNESS	-0.858	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 464 MISSING CASES 1

FILE CLIENT (CREATION DATE = 03/23/83)

SUBFILE NC NW SE WC LR SC NE

X6 SUICIDE

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY AGREE	1.	117	25.2	25.3	25.3
AGREE	2.	247	53.1	53.3	78.6
NEUTRAL	3.	60	12.9	13.0	91.6
DISAGREE	4.	28	6.0	6.0	97.6
STRONGLY DISAGREE	5.	11	2.4	2.4	100.0
	9.	2	0.4	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	2.069	STD ERR	0.042	MEDIAN	1.964
MODE	2.000	STD DEV	0.914	VARIANCE	0.835
KURTOSIS	1.379	SKEWNESS	1.094	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 463 MISSING CASES 2

PROGRAM FOR ALL SUBFILES 03/23/83 PAGE 15

FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X7 CENTRAL REGISTRY

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY AGREE	1.	5	1.1	1.1	1.1
AGREE	2.	66	14.2	14.3	15.3
NEUTRAL	3.	81	17.4	17.5	32.8
DISAGREE	4.	163	35.1	35.2	68.0
STRONGLY DISAGREE	5.	148	31.8	32.0	100.0
	9.	2	0.4	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	3.827	STD ERR	0.050	MEDIAN	3.988
MODE	4.000	STD DEV	1.065	VARIANCE	1.135
KURTOSIS	-0.680	SKEWNESS	-0.579	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 463 MISSING CASES 2

PROGRAM FOR ALL SUBFILES 03/23/83 PAGE 16

FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X8 TRAFFIC SAFETY

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY AGREE	1.	44	9.5	9.7	9.7
AGREE	2.	162	34.8	35.7	45.4
NEUTRAL	3.	110	23.7	24.2	69.6
DISAGREE	4.	113	24.3	24.9	94.5
STRONGLY DISAGREE	5.	25	5.4	5.5	100.0
	9.	11	2.4	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	2.808	STD ERR	0.051	MEDIAN	2.691
MODE	2.000	STD DEV	1.086	VARIANCE	1.180
KURTOSIS	-0.858	SKEWNESS	0.189	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 454 MISSING CASES 11

PROGRAM FOR ALL SUBFILES 03/23/83 PAGE 17

FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X9 EXPECTATION

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY DISAGREE	1.	1	0.2	0.2	0.2
DISAGREE	2.	21	4.5	4.6	4.8
NEUTRAL	3.	34	7.3	7.4	12.3
AGREE	4.	233	50.1	51.0	63.2
STRONGLY AGREE	5.	168	36.1	36.8	100.0
	9.	8	1.7	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	4.195	STD ERR	0.037	MEDIAN	4.240
MODE	4.000	STD DEV	0.780	VARIANCE	0.609
KURTOSIS	1.365	SKEWNESS	-1.050	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 457 MISSING CASES 8

PROGRAM FOR ALL SUBFILES 03/23/83 PAGE 18

FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X10 PRIVACY

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY DISAGREE	1.	34	7.3	7.5	7.5
DISAGREE	2.	159	34.2	34.9	42.3
NEUTRAL	3.	176	37.8	38.6	80.9
AGREE	4.	64	13.8	14.0	95.0
STRONGLY AGREE	5.	23	4.9	5.0	100.0
	9.	9	1.9	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	2.743	STD ERR	0.045	MEDIAN	2.699
MODE	3.000	STD DEV	0.962	VARIANCE	0.925
KURTOSIS	-0.108	SKEWNESS	0.369	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 456 MISSING CASES 9

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FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X11 THERAPIST OBLIGATION

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY DISAGREE	1.	1	0.2	0.2	0.2
DISAGREE	2.	6	1.3	1.3	1.5
NEUTRAL	3.	29	6.2	6.3	7.9
AGREE	4.	244	52.5	53.4	61.3
STRONGLY AGREE	5.	177	38.1	38.7	100.0
	9.	8	1.7	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	4.291	STD ERR	0.031	MEDIAN	4.289
MODE	4.000	STD DEV	0.663	VARIANCE	0.439
KURTOSIS	1.698	SKEWNESS	-0.856	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 457 MISSING CASES 8

PROGRAM FOR ALL SUBFILES 03/23/83 PAGE 20

FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X12 ABSOLUTE

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY DISAGREE	1.	2	0.4	0.4	0.4
DISAGREE	2.	53	11.4	11.7	12.1
NEUTRAL	3.	56	12.0	12.4	24.5
AGREE	4.	187	40.2	41.3	65.8
STRONGLY AGREE	5.	155	33.3	34.2	100.0
	9.	12	2.6	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	3.971	STD ERR	0.046	MEDIAN	4.118
MODE	4.000	STD DEV	0.987	VARIANCE	0.975
KURTOSIS	-0.237	SKEWNESS	-0.787	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 453 MISSING CASES 12

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FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X13 RECORD KEEPING

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY AGREE	1.	159	34.2	34.9	34.9
AGREE	2.	267	57.4	58.6	93.4
NEUTRAL	3.	22	4.7	4.8	98.2
DISAGREE	4.	7	1.5	1.5	99.8
STRONGLY DISAGREE	5.	1	0.2	0.2	100.0
	9.	9	1.9	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	1.737	STD ERR	0.030	MEDIAN	1.758
MODE	2.000	STD DEV	0.640	VARIANCE	0.410
KURTOSIS	2.302	SKEWNESS	0.854	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 456 MISSING CASES 9

FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X14 CHILD ABUSE

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY AGREE	1.	132	28.4	29.3	29.3
AGREE	2.	203	43.7	45.0	74.3
NEUTRAL	3.	76	16.3	16.9	91.1
DISAGREE	4.	36	7.7	8.0	99.1
STRONGLY DISAGREE	5.	4	0.9	0.9	100.0
	9.	14	3.0	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	2.062	STD ERR	0.044	MEDIAN	1.961
MODE	2.000	STD DEV	0.926	VARIANCE	0.858
KURTOSIS	0.136	SKEWNESS	0.752	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 451 MISSING CASES 14

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FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X15 SENSITIVE JOB

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY AGREE	1.	67	14.4	14.8	14.8
AGREE	2.	204	43.9	45.1	60.0
NEUTRAL	3.	115	24.7	25.4	85.4
DISAGREE	4.	57	12.3	12.6	98.0
STRONGLY DISAGREE	5.	9	1.9	2.0	100.0
	9.	13	2.8	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	2.418	STD ERR	0.045	MEDIAN	2.279
MODE	2.000	STD DEV	0.956	VARIANCE	0.913
KURTOSIS	-0.200	SKEWNESS	0.503	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 452 MISSING CASES 13

FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X16 CRIME

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY DISAGREE	1.	19	4.1	4.3	4.3
DISAGREE	2.	96	20.6	21.6	25.8
NEUTRAL	3.	162	34.8	36.4	62.2
AGREE	4.	124	26.7	27.9	90.1
STRONGLY AGREE	5.	44	9.5	9.9	100.0
	9.	20	4.3	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	3.175	STD ERR	0.048	MEDIAN	3.164
MODE	3.000	STD DEV	1.016	VARIANCE	1.032
KURTOSIS	-0.548	SKEWNESS	-0.033	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 445 MISSING CASES 20

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FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X17 PREFERENCE

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
DISAGREE	2.	7	1.5	1.5	1.5
NEUTRAL	3.	54	11.6	11.8	13.3
AGREE	4.	214	46.0	46.6	59.9
STRONGLY AGREE	5.	184	39.6	40.1	100.0
	9.	6	1.3	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	4.253	STD ERR	0.034	MEDIAN	4.287
MODE	4.000	STD DEV	0.719	VARIANCE	0.517
KURTOSIS	0.058	SKEWNESS	-0.666	RANGE	3.000
MINIMUM	2.000	MAXIMUM	5.000		

VALID CASES 459 MISSING CASES 6

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FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X18 INFORMED CONSENT

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY DISAGREE	1.	1	0.2	0.2	0.2
DISAGREE	2.	7	1.5	1.5	1.8
NEUTRAL	3.	24	5.2	5.3	7.0
AGREE	4.	268	57.6	58.9	65.9
STRONGLY AGREE	5.	155	33.3	34.1	100.0
	9.	10	2.2	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	4.251	STD ERR	0.030	MEDIAN	4.229
MODE	4.000	STD DEV	0.643	VARIANCE	0.413
KURTOSIS	2.216	SKEWNESS	-0.834	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 455 MISSING CASES 10

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FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X19 TARASOFF

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY DISAGREE	1.	90	19.4	20.0	20.0
DISAGREE	2.	240	51.6	53.3	73.3
NEUTRAL	3.	84	18.1	18.7	92.0
AGREE	4.	28	6.0	6.2	98.2
STRONGLY AGREE	5.	8	1.7	1.8	100.0
	9.	15	3.2	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	2.164	STD ERR	0.041	MEDIAN	2.063
MODE	2.000	STD DEV	0.878	VARIANCE	0.770
KURTOSIS	0.943	SKEWNESS	0.865	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 450 MISSING CASES 15

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FILE CLIENT (CREATION DATE = 03/23/83)
SUBFILE NC NW SE WC LR SC NE

X20 CONSULTATION

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
STRONGLY AGREE	1.	71	15.3	15.6	15.6
AGREE	2.	264	56.8	57.9	73.5
NEUTRAL	3.	77	16.6	16.9	90.4
DISAGREE	4.	34	7.3	7.5	97.8
STRONGLY DISAGREE	5.	10	2.2	2.2	100.0
	9.	9	1.9	MISSING	100.0
	TOTAL	465	100.0	100.0	

MEAN	2.228	STD ERR	0.041	MEDIAN	2.095
MODE	2.000	STD DEV	0.877	VARIANCE	0.770
KURTOSIS	1.170	SKEWNESS	0.990	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 456 MISSING CASES 9

APPENDIX J

TEST RELIABILITY DATA

PROGRAM FOR ALL SUBFILES 03/29/83 PAGE 8

FILE CLIENT (CREATION DATE = 03/29/83)

SUBFILE NC NW SE WC LR SC NE

**********RELIABILITY ANALYSIS FOR SCALE (ATTITUDE)**********

1.	X1	RECORD ACCESS
2.	X2	COURT ORDER
3.	X3	OPENNESS
4.	X4	NATIONAL SECURITY
5.	X5	TEENAGER
6.	X6	SUICIDE
7.	X7	CENTRAL REGISTRY
8.	X8	TRAFFIC SAFETY
9.	X9	EXPECTATION
10.	X10	PRIVACY
11.	X11	THERAPIST OBLIGATION
12.	X12	ABSOLUTE
13.	X13	RECORD KEEPING
14.	X14	CHILD ABUSE
15.	X15	SENSITIVE JOB
16.	X16	CRIME
17.	X17	PREFERENCE
18.	X18	INFORMED CONSENT
19.	X19	TARASOFF
20.	X20	CONSULTATION

		MEANS	STD DEV	CASES
1.	X1	3.79087	1.13520	416.0
2.	X2	3.68510	1.11046	416.0
3.	X3	4.53365	0.69339	416.0
4.	X4	2.58173	1.10336	416.0
5.	X5	3.81010	1.07546	416.0
6.	X6	2.07212	0.91814	416.0
7.	X7	3.81010	1.06646	416.0
8.	X8	2.79808	1.08997	416.0
9.	X9	4.18029	0.77844	416.0
10.	X10	2.74038	0.96188	416.0
11.	X11	4.27644	0.67164	416.0
12.	X12	3.97596	0.98880	416.0
13.	X13	1.74519	0.65306	416.0
14.	X14	2.08173	0.91995	416.0
15.	X15	2.39663	0.94366	416.0
16.	X16	3.19471	1.02408	416.0
17.	X17	4.22115	0.72420	416.0
18.	X18	4.24279	0.65580	416.0
19.	X19	2.18269	0.88374	416.0
20.	X20	2.23798	0.88009	416.0

STATISTICS FOR	MEAN	VARIANCE	STD DEV	# VARIABLES
SCALE	64.55769	64.68100	8.04245	20

FILE CLIENT (CREATION DATE = 03/29/83)
SUBFILE NC NW SE WC LR SC NE

**********RELIABILITY ANALYSIS FOR SCALE (ATTITUDE)**********

ITEM-TOTAL STATISTICS

	SCALE MEAN IF ITEM DELETED	SCALE VARIANCE IF ITEM DELETED	CORRECTED ITEM-TOTAL CORRELATION	ALPHA IF ITEM DELETED
X1	60.76683	61.35514	0.11455	0.78135
X2	60.87260	57.55722	0.34961	0.76224
X3	60.02404	60.97773	0.29757	0.76567
X4	61.97596	55.50304	0.48422	0.75109
X5	60.74760	57.37469	0.37746	0.75990
X6	62.48558	58.77088	0.35995	0.76129
X7	60.74760	58.49758	0.30932	0.76522
X8	61.75962	55.33967	0.50277	0.74962
X9	60.37740	61.85481	0.18132	0.77191
X10	61.81731	60.56895	0.21286	0.77146
X11	60.28125	59.79782	0.42667	0.75942
X12	60.58173	58.02704	0.37679	0.75997
X13	62.81250	64.49488	-0.02292	0.78059
X14	62.47596	58.35123	0.39015	0.75923
X15	62.16106	57.20050	0.46168	0.75409
X16	61.36298	56.58359	0.45751	0.75375
X17	60.33654	59.21177	0.44366	0.75780
X18	60.31490	61.41144	0.27626	0.76684
X19	62.37500	57.64217	0.46633	0.75439
X20	62.31971	60.96501	0.21402	0.77069

RELIABILITY COEFFICIENTS
N OF CASES = 416.0 N OF ITEMS = 20
ALPHA = 0.77227

APPENDIX K

CORRELATIONS OF THE VARIABLES

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FILE CLIENT (CREATION DATE = 04/13/83)

SUBFILE NC NW SE WC LR SC NE

PEARSON CORRELATION COEFFICIENTS

	X1	X2	X3	X4	X5	X6	X7	X8	X9	X10
X1	1.0000	-0.0769	0.0358	0.1386	0.0311	-0.0093	0.2178	0.1211	-0.0218	0.1083
	(464)	(461)	(464)	(455)	(463)	(462)	(462)	(453)	(456)	(455)
	P=*****	P=0.050	P=0.221	P=0.002	P=0.252	P=0.421	P=0.000	P=0.005	P=0.321	P=0.010
X2	-0.0769	1.0000	0.2180	0.1459	0.1748	0.1933	0.0580	0.1174	0.2061	0.1021
	(461)	(462)	(462)	(454)	(461)	(460)	(461)	(452)	(454)	(453)
	P=0.050	P=*****	P=0.000	P=0.001	P=0.000	P=0.000	P=0.107	P=0.006	P=0.000	P=0.015
X3	0.0358	0.2180	1.0000	0.0305	0.2388	-0.0135	0.1318	0.1384	0.3342	0.0782
	(464)	(462)	(465)	(456)	(464)	(463)	(463)	(454)	(457)	(456)
	P=0.221	P=0.000	P=*****	P=0.258	P=0.000	P=0.386	P=0.002	P=0.002	P=0.000	P=0.048
X4	0.1386	0.1459	0.0305	1.0000	0.1948	0.3195	0.1888	0.3757	-0.0003	0.1180
	(455)	(454)	(456)	(456)	(455)	(455)	(456)	(447)	(448)	(447)
	P=0.002	P=0.001	P=0.258	P=*****	P=0.000	P=0.000	P=0.000	P=0.000	P=0.497	P=0.006
X5	0.0311	0.1748	0.2388	0.1948	1.0000	0.1277	0.1887	0.2775	0.1718	0.0984
	(463)	(461)	(464)	(455)	(464)	(462)	(462)	(453)	(456)	(455)
	P=0.252	P=0.000	P=0.000	P=0.000	P=*****	P=0.003	P=0.000	P=0.000	P=0.000	P=0.018
X6	-0.0093	0.1933	-0.0135	0.3195	0.1277	1.0000	0.0949	0.3191	-0.0029	0.0925
	(462)	(460)	(463)	(455)	(462)	(463)	(461)	(452)	(455)	(454)
	P=0.421	P=0.000	P=0.386	P=0.000	P=0.003	P=*****	P=0.021	P=0.000	P=0.476	P=0.024
X7	0.2178	0.0580	0.1318	0.1888	0.1887	0.0949	1.0000	0.2104	0.0737	0.0835
	(462)	(461)	(463)	(456)	(462)	(461)	(463)	(453)	(455)	(454)
	P=0.000	P=0.107	P=0.002	P=0.000	P=0.000	P=0.021	P=*****	P=0.000	P=0.058	P=0.038
X8	0.1211	0.1174	0.1384	0.3757	0.2775	0.3191	0.2104	1.0000	0.0435	0.1311
	(453)	(452)	(454)	(447)	(453)	(452)	(453)	(454)	(453)	(452)
	P=0.005	P=0.006	P=0.002	P=0.000	P=0.000	P=0.000	P=0.000	P=*****	P=0.178	P=0.003
X9	-0.0218	0.2061	0.3342	-0.0003	0.1718	-0.0029	0.0737	0.0435	1.0000	0.0095
	(456)	(454)	(457)	(448)	(456)	(455)	(455)	(453)	(457)	(455)
	P=0.321	P=0.000	P=0.000	P=0.497	P=0.000	P=0.476	P=0.058	P=0.178	P=*****	P=0.420
X10	0.1083	0.1021	0.0782	0.1180	0.0984	0.0925	0.0835	0.1311	0.0095	1.0000
	(455)	(453)	(456)	(447)	(455)	(454)	(454)	(452)	(455)	(456)
	P=0.010	P=0.015	P=0.048	P=0.006	P=0.018	P=0.024	P=0.038	P=0.003	P=0.420	P=*****
X11	0.0594	0.2671	0.3386	0.1433	0.1969	-0.0361	0.2016	0.1775	0.3195	0.1632
	(456)	(455)	(457)	(448)	(456)	(455)	(455)	(453)	(456)	(455)
	P=0.103	P=0.000	P=0.000	P=0.001	P=0.000	P=0.221	P=0.000	P=0.000	P=0.000	P=0.000

(COEFFICIENT / (CASES) / SIGNIFICANCE) (A VALUE OF 99.0000 IS PRINTED IF A COEFFICIENT CANNOT BE COMPUTED)

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FILE CLIENT (CREATION DATE = 04/13/83)

SUBFILE NC NW SE WC LR SC NE

PEARSON CORRELATION COEFFICIENTS

	X1	X2	X3	X4	X5	X6	X7	X8	X9	X10
X12	0.0438	0.2606	0.3669	0.1031	0.2311	0.0664	0.0497	0.1313	0.3310	0.0974
	(452)	(450)	(453)	(445)	(452)	(451)	(451)	(449)	(453)	(451)
	P=0.177	P=0.000	P=0.000	P=0.015	P=0.000	P=0.080	P=0.146	P=0.003	P=0.000	P=0.019
X13	-0.0028	0.0316	-0.2405	0.1066	-0.0887	0.1957	-0.0247	0.0792	-0.3099	-0.0122
	(455)	(453)	(456)	(447)	(455)	(454)	(454)	(452)	(455)	(455)
	P=0.477	P=0.251	P=0.000	P=0.012	P=0.029	P=0.000	P=0.300	P=0.046	P=0.000	P=0.398
X14	-0.0884	0.1376	0.0991	0.3481	0.1718	0.3463	0.0875	0.3647	-0.0569	0.0185
	(450)	(449)	(451)	(445)	(450)	(450)	(450)	(448)	(450)	(449)
	P=0.031	P=0.002	P=0.018	P=0.000	P=0.000	P=0.000	P=0.032	P=0.000	P=0.114	P=0.348
X15	0.0351	0.1517	0.0528	0.4531	0.2567	0.3951	0.1441	0.4481	-0.0376	0.1259
	(451)	(451)	(452)	(444)	(452)	(450)	(451)	(450)	(451)	(450)
	P=0.228	P=0.001	P=0.131	P=0.000	P=0.000	P=0.000	P=0.001	P=0.000	P=0.213	P=0.004
X16	0.0103	0.3088	0.2488	0.2802	0.2306	0.1784	0.1368	0.2834	0.1694	0.0931
	(444)	(444)	(445)	(440)	(445)	(444)	(444)	(438)	(438)	(437)
	P=0.414	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.002	P=0.000	P=0.000	P=0.026
X17	0.0854	0.2804	0.3358	0.1155	0.1678	0.0217	0.2160	0.2026	0.3568	0.2753
	(458)	(456)	(459)	(450)	(458)	(457)	(457)	(449)	(452)	(451)
	P=0.034	P=0.000	P=0.000	P=0.007	P=0.000	P=0.322	P=0.000	P=0.000	P=0.000	P=0.000
X18	0.1606	0.0708	0.1925	0.1660	0.1620	-0.0203	0.1524	0.1049	0.1917	0.1100
	(454)	(452)	(455)	(447)	(454)	(453)	(453)	(446)	(449)	(448)
	P=0.000	P=0.066	P=0.000	P=0.000	P=0.000	P=0.333	P=0.001	P=0.013	P=0.000	P=0.010
X19	-0.0122	0.2383	0.0555	0.3886	0.1550	0.4194	0.1184	0.3532	0.0511	0.1341
	(449)	(448)	(450)	(443)	(449)	(449)	(449)	(441)	(443)	(442)
	P=0.398	P=0.000	P=0.120	P=0.000	P=0.000	P=0.000	P=0.006	P=0.000	P=0.141	P=0.002
X20	0.0736	0.0917	-0.0103	0.2264	0.0427	0.1870	0.0973	0.1818	-0.0227	0.0606
	(455)	(454)	(456)	(449)	(455)	(454)	(455)	(447)	(449)	(448)
	P=0.058	P=0.025	P=0.413	P=0.000	P=0.182	P=0.000	P=0.019	P=0.000	P=0.316	P=0.100
Y6	0.0267	-0.0603	0.1151	-0.0509	0.1112	-0.1048	0.1206	-0.0346	0.0371	-0.0199
	(457)	(455)	(458)	(449)	(457)	(456)	(456)	(448)	(451)	(450)
	P=0.285	P=0.100	P=0.007	P=0.141	P=0.009	P=0.013	P=0.005	P=0.232	P=0.216	P=0.337
Y7	-0.0279	-0.0987	-0.0392	-0.0971	-0.1997	-0.1418	0.0474	-0.0367	-0.0001	-0.0426
	(453)	(451)	(454)	(445)	(453)	(452)	(452)	(445)	(447)	(446)
	P=0.277	P=0.018	P=0.202	P=0.020	P=0.000	P=0.001	P=0.157	P=0.220	P=0.499	P=0.185

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FILE CLIENT (CREATION DATE = 04/13/83)

SUBFILE NC NW SE WC LR SC NE

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	X1	X2	X3	X4	X5	X6	X7	X8	X9	X10
Y8	0.0955	-0.0134	0.0787	0.1410	0.1716	-0.0487	0.2338	0.1789	-0.0264	0.1766
	(448)	(446)	(449)	(440)	(448)	(447)	(447)	(439)	(442)	(441)
	P=0.022	P=0.389	P=0.048	P=0.002	P=0.000	P=0.152	P=0.000	P=0.000	P=0.290	P=0.000
Y9	0.0116	0.0443	0.0528	0.0207	0.0770	0.0379	0.0747	0.1132	0.0140	-0.0613
	(451)	(449)	(452)	(444)	(451)	(450)	(450)	(442)	(445)	(444)
	P=0.403	P=0.175	P=0.131	P=0.332	P=0.051	P=0.211	P=0.057	P=0.009	P=0.384	P=0.099
Y10	0.0510	-0.0262	0.0075	0.0034	-0.0938	-0.0430	0.0781	0.0593	-0.0207	0.0613
	(457)	(455)	(458)	(449)	(457)	(456)	(456)	(448)	(451)	(450)
	P=0.138	P=0.289	P=0.437	P=0.472	P=0.023	P=0.180	P=0.048	P=0.105	P=0.331	P=0.097
Y12	0.0984	-0.0888	-0.0019	0.0060	0.0065	-0.0769	0.0581	0.0077	-0.0601	0.0272
	(458)	(456)	(459)	(450)	(458)	(457)	(457)	(448)	(451)	(450)
	P=0.018	P=0.029	P=0.484	P=0.450	P=0.445	P=0.050	P=0.108	P=0.436	P=0.101	P=0.282
Y13	0.0106	-0.0288	0.0224	-0.0242	0.0650	-0.0166	0.0266	0.0487	0.0375	-0.0768
	(456)	(454)	(457)	(448)	(456)	(455)	(455)	(446)	(449)	(448)
	P=0.410	P=0.270	P=0.317	P=0.305	P=0.083	P=0.362	P=0.286	P=0.152	P=0.214	P=0.052
Y14	-0.0307	0.0106	0.0670	-0.0250	-0.0613	-0.1385	0.0573	-0.0332	0.0445	-0.0394
	(439)	(437)	(440)	(431)	(439)	(438)	(438)	(430)	(433)	(432)
	P=0.261	P=0.412	P=0.080	P=0.302	P=0.100	P=0.002	P=0.116	P=0.246	P=0.178	P=0.207
Y15	0.0279	-0.0252	0.0893	0.0729	0.0059	-0.1360	0.1006	0.0323	0.0528	-0.0369
	(449)	(447)	(450)	(441)	(449)	(448)	(448)	(439)	(442)	(441)
	P=0.278	P=0.297	P=0.029	P=0.063	P=0.450	P=0.002	P=0.017	P=0.250	P=0.134	P=0.220
Y16	0.0106	0.0687	0.0285	0.0933	0.0823	-0.0008	0.1052	0.0828	0.0208	0.0563
	(455)	(453)	(456)	(447)	(455)	(454)	(454)	(445)	(448)	(447)
	P=0.411	P=0.072	P=0.272	P=0.024	P=0.040	P=0.493	P=0.013	P=0.040	P=0.330	P=0.117
Y17	0.0618	0.0994	0.1292	0.1123	0.0078	0.1337	0.1629	0.0624	-0.0065	0.1808
	(450)	(448)	(451)	(442)	(450)	(449)	(449)	(440)	(443)	(443)
	P=0.095	P=0.018	P=0.003	P=0.009	P=0.434	P=0.002	P=0.000	P=0.096	P=0.446	P=0.000
Y18	0.0175	0.1407	0.0545	-0.0165	0.0850	0.0738	0.0932	-0.0440	-0.0057	0.0486
	(448)	(446)	(449)	(440)	(448)	(448)	(447)	(438)	(441)	(440)
	P=0.356	P=0.001	P=0.124	P=0.365	P=0.036	P=0.059	P=0.025	P=0.179	P=0.453	P=0.155
Y19	-0.2035	-0.2129	-0.1722	-0.1173	-0.2289	-0.1349	-0.2231	-0.2279	-0.1856	-0.1908
	(442)	(441)	(443)	(435)	(442)	(441)	(442)	(434)	(436)	(435)
	P=0.000	P=0.000	P=0.000	P=0.007	P=0.000	P=0.002	P=0.000	P=0.000	P=0.000	P=0.000

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FILE CLIENT (CREATION DATE = 04/13/83)

SUBFILE NC NW SE WC LR SC NE

PEARSON CORRELATION COEFFICIENTS

	X1	X2	X3	X4	X5	X6	X7	X8	X9	X10
X32	0.2542	0.4161	0.3363	0.5563	0.4510	0.4137	0.3372	0.5814	0.2736	0.3088
	(463)	(461)	(464)	(455)	(463)	(462)	(462)	(454)	(457)	(456)
	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000
X31	0.2425	0.4599	0.3950	0.5787	0.4812	0.4640	0.4131	0.6037	0.2986	0.3301
	(463)	(461)	(464)	(455)	(463)	(462)	(462)	(454)	(457)	(456)
	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000
Y30	0.0627	-0.1026	0.0049	-0.0021	0.0222	-0.0494	0.0770	0.0696	0.0103	-0.0437
	(456)	(454)	(457)	(448)	(456)	(455)	(455)	(446)	(449)	(448)
	P=0.091	P=0.014	P=0.458	P=0.482	P=0.318	P=0.146	P=0.050	P=0.071	P=0.414	P=0.178
Y31	-0.0114	0.0250	0.0619	0.1094	-0.0022	-0.0679	0.0787	0.0713	0.0231	-0.0593
	(439)	(437)	(440)	(431)	(439)	(438)	(438)	(430)	(433)	(432)
	P=0.406	P=0.301	P=0.097	P=0.012	P=0.482	P=0.078	P=0.050	P=0.070	P=0.316	P=0.109
Y32	0.0239	-0.0991	0.0328	0.0418	0.0385	-0.1265	0.1042	-0.0118	-0.0247	0.1889
	(435)	(433)	(436)	(427)	(435)	(434)	(434)	(426)	(429)	(428)
	P=0.310	P=0.020	P=0.247	P=0.194	P=0.212	P=0.004	P=0.015	P=0.404	P=0.305	P=0.000

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FILE CLIENT (CREATION DATE = 04/13/83)

SUBFILE NC NW SE WC LR SC NE

- - - - - - - - - - - - - - - P E A R S O N C O R R E L A T I O N C O E F F I C I E N T S - - - - - - - - - - - - - - -

	X11	X12	X13	X14	X15	X16	X17	X18	X19	X20
X1	0.0594	0.0438	-0.0028	-0.0884	0.0351	0.0103	0.0854	0.1606	-0.0122	0.0736
	(456)	(452)	(455)	(450)	(451)	(444)	(458)	(454)	(449)	(455)
	P=0.103	P=0.177	P=0.477	P=0.031	P=0.228	P=0.414	P=0.034	P=0.000	P=0.398	P=0.058
X2	0.2671	0.2606	0.0316	0.1376	0.1517	0.3088	0.2804	0.0708	0.2383	0.0917
	(455)	(450)	(453)	(449)	(451)	(444)	(456)	(452)	(448)	(454)
	P=0.000	P=0.000	P=0.251	P=0.002	P=0.001	P=0.000	P=0.000	P=0.066	P=0.000	P=0.025
X3	0.3386	0.3669	-0.2405	0.0991	0.0528	0.2488	0.3358	0.1925	0.0555	-0.0103
	(457)	(453)	(456)	(451)	(452)	(445)	(459)	(455)	(450)	(456)
	P=0.000	P=0.000	P=0.000	P=0.018	P=0.131	P=0.000	P=0.000	P=0.000	P=0.120	P=0.413
X4	0.1433	0.1031	0.1066	0.3481	0.4531	0.2802	0.1155	0.1660	0.3886	0.2264
	(448)	(445)	(447)	(445)	(444)	(440)	(450)	(447)	(443)	(449)
	P=0.001	P=0.015	P=0.012	P=0.000	P=0.000	P=0.000	P=0.007	P=0.000	P=0.000	P=0.000
X5	0.1969	0.2311	-0.0887	0.1718	0.2567	0.2306	0.1678	0.1620	0.1550	0.0427
	(456)	(452)	(455)	(450)	(452)	(445)	(458)	(454)	(449)	(455)
	P=0.000	P=0.000	P=0.029	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.182
X6	-0.0361	0.0664	0.1957	0.3463	0.3951	0.1784	0.0217	-0.0203	0.4194	0.1870
	(455)	(451)	(454)	(450)	(450)	(444)	(457)	(453)	(449)	(454)
	P=0.221	P=0.080	P=0.000	P=0.000	P=0.000	P=0.000	P=0.322	P=0.333	P=0.000	P=0.000
X7	0.2016	0.0497	-0.0247	0.0875	0.1441	0.1368	0.2160	0.1524	0.1184	0.0973
	(455)	(451)	(454)	(450)	(451)	(444)	(457)	(453)	(449)	(455)
	P=0.000	P=0.146	P=0.300	P=0.032	P=0.001	P=0.002	P=0.000	P=0.001	P=0.006	P=0.019
X8	0.1775	0.1313	0.0792	0.3647	0.4481	0.2834	0.2026	0.1049	0.3532	0.1818
	(453)	(449)	(452)	(448)	(450)	(438)	(449)	(446)	(441)	(447)
	P=0.000	P=0.003	P=0.046	P=0.000	P=0.000	P=0.000	P=0.000	P=0.013	P=0.000	P=0.000
X9	0.3195	0.3310	-0.3099	-0.0569	-0.0376	0.1694	0.3568	0.1917	0.0511	-0.0227
	(456)	(453)	(455)	(450)	(451)	(438)	(452)	(449)	(443)	(449)
	P=0.000	P=0.000	P=0.000	P=0.114	P=0.213	P=0.000	P=0.000	P=0.000	P=0.141	P=0.316
X10	0.1632	0.0974	-0.0122	0.0185	0.1259	0.0931	0.2753	0.1100	0.1341	0.0606
	(455)	(451)	(455)	(449)	(450)	(437)	(451)	(448)	(442)	(448)
	P=0.000	P=0.019	P=0.398	P=0.348	P=0.004	P=0.026	P=0.000	P=0.010	P=0.002	P=0.100
X11	1.0000	0.4284	-0.2013	0.0854	0.0593	0.3024	0.5662	0.3707	0.1076	0.0287
	(457)	(452)	(455)	(450)	(451)	(438)	(452)	(449)	(443)	(449)
	P=*****	P=0.000	P=0.000	P=0.035	P=0.104	P=0.000	P=0.000	P=0.000	P=0.012	P=0.272

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FILE CLIENT (CREATION DATE = 04/13/83)

SUBFILE NC NW SE WC LR SC NE

PEARSON CORRELATION COEFFICIENTS

	X11	X12	X13	X14	X15	X16	X17	X18	X19	X20
X12	0.4284	1.0000	-0.2316	0.1179	-0.0122	0.3419	0.4002	0.2804	0.1587	0.0625
	(452)	(453)	(451)	(446)	(447)	(434)	(448)	(446)	(439)	(445)
	P=0.000	P=*****	P=0.000	P=0.006	P=0.398	P=0.000	P=0.000	P=0.000	P=0.000	P=0.094
X13	-0.2013	-0.2316	1.0000	0.1459	0.2061	-0.0836	-0.2370	-0.2399	0.1270	0.2486
	(455)	(451)	(456)	(449)	(450)	(437)	(451)	(448)	(442)	(448)
	P=0.000	P=0.000	P=*****	P=0.001	P=0.000	P=0.040	P=0.000	P=0.000	P=0.004	P=0.000
X14	0.0854	0.1179	0.1459	1.0000	0.4631	0.2213	0.0582	-0.0297	0.3493	0.1690
	(450)	(446)	(449)	(451)	(447)	(438)	(446)	(444)	(440)	(444)
	P=0.035	P=0.006	P=0.001	P=*****	P=0.000	P=0.000	P=0.110	P=0.266	P=0.000	P=0.000
X15	0.0593	-0.0122	0.2061	0.4631	1.0000	0.2558	0.1215	0.0	0.4254	0.1925
	(451)	(447)	(450)	(447)	(452)	(438)	(447)	(444)	(440)	(445)
	P=0.104	P=0.398	P=0.000	P=0.000	P=*****	P=0.000	P=0.005	P=0.500	P=0.000	P=0.000
X16	0.3024	0.3419	-0.0836	0.2213	0.2558	1.0000	0.2825	0.2041	0.3482	-0.0319
	(438)	(434)	(437)	(438)	(438)	(445)	(445)	(442)	(440)	(443)
	P=0.000	P=0.000	P=0.040	P=0.000	P=0.000	P=*****	P=0.000	P=0.000	P=0.000	P=0.252
X17	0.5662	0.4002	-0.2370	0.0582	0.1215	0.2825	1.0000	0.3702	0.0807	0.0496
	(452)	(448)	(451)	(446)	(447)	(445)	(459)	(455)	(450)	(456)
	P=0.000	P=0.000	P=0.000	P=0.110	P=0.005	P=0.000	P=*****	P=0.000	P=0.044	P=0.145
X18	0.3707	0.2804	-0.2399	-0.0297	0.0	0.2041	0.3702	1.0000	0.0259	0.0176
	(449)	(446)	(448)	(444)	(444)	(442)	(455)	(455)	(447)	(452)
	P=0.000	P=0.000	P=0.000	P=0.266	P=0.500	P=0.000	P=0.000	P=*****	P=0.292	P=0.355
X19	0.1076	0.1587	0.1270	0.3493	0.4254	0.3482	0.0807	0.0259	1.0000	0.2139
	(443)	(439)	(442)	(440)	(440)	(440)	(450)	(447)	(450)	(448)
	P=0.012	P=0.000	P=0.004	P=0.000	P=0.000	P=0.000	P=0.044	P=0.292	P=*****	P=0.000
X20	0.0287	0.0625	0.2486	0.1690	0.1925	-0.0319	0.0496	0.0176	0.2139	1.0000
	(449)	(445)	(448)	(444)	(445)	(443)	(456)	(452)	(448)	(456)
	P=0.272	P=0.094	P=0.000	P=0.000	P=0.000	P=0.252	P=0.145	P=0.355	P=0.000	P=*****
Y6	0.0594	0.0128	-0.1028	-0.0161	-0.0241	-0.0215	0.0766	0.1001	-0.0398	-0.0423
	(451)	(447)	(450)	(445)	(446)	(444)	(458)	(454)	(449)	(455)
	P=0.104	P=0.394	P=0.015	P=0.368	P=0.306	P=0.326	P=0.051	P=0.017	P=0.200	P=0.184
Y7	0.0510	-0.0387	-0.0171	0.0079	-0.0739	-0.0230	0.0359	-0.0007	-0.0638	-0.0944
	(447)	(443)	(446)	(441)	(443)	(441)	(454)	(450)	(445)	(451)
	P=0.141	P=0.208	P=0.360	P=0.434	P=0.060	P=0.315	P=0.223	P=0.494	P=0.089	P=0.023

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SUBFILE NC NW SE WC LR SC NE

PEARSON CORRELATION COEFFICIENTS

	X11	X12	X13	X14	X15	X16	X17	X18	X19	X20
Y8	0.1654	-0.1156	0.0195	0.0441	0.1761	-0.0205	0.0776	0.1176	0.0496	-0.0300
	(442)	(438)	(441)	(436)	(437)	(435)	(449)	(445)	(440)	(446)
	P=0.000	P=0.008	P=0.341	P=0.179	P=0.000	P=0.335	P=0.050	P=0.007	P=0.150	P=0.263
Y9	-0.0011	-0.0498	0.0936	0.0284	0.1965	0.0272	-0.0109	-0.0345	0.0645	0.0803
	(445)	(441)	(444)	(439)	(440)	(438)	(452)	(448)	(444)	(450)
	P=0.491	P=0.148	P=0.024	P=0.277	P=0.000	P=0.285	P=0.408	P=0.233	P=0.087	P=0.044
Y10	0.0173	-0.0198	-0.0392	0.0201	0.0299	-0.0121	0.0439	0.0069	-0.0293	0.0327
	(451)	(447)	(450)	(445)	(446)	(444)	(458)	(454)	(449)	(455)
	P=0.357	P=0.338	P=0.203	P=0.336	P=0.264	P=0.399	P=0.174	P=0.442	P=0.268	P=0.244
Y12	-0.0291	0.0280	0.0256	-0.0133	-0.0262	-0.0081	-0.0275	-0.0855	-0.1353	0.0342
	(451)	(447)	(450)	(445)	(446)	(439)	(453)	(449)	(444)	(450)
	P=0.269	P=0.278	P=0.294	P=0.390	P=0.290	P=0.433	P=0.280	P=0.035	P=0.002	P=0.235
Y13	0.0641	0.1169	-0.0751	0.0069	-0.0025	0.0430	0.0622	0.1819	-0.0253	-0.0377
	(449)	(445)	(448)	(443)	(444)	(437)	(451)	(447)	(442)	(448)
	P=0.088	P=0.007	P=0.056	P=0.442	P=0.479	P=0.185	P=0.094	P=0.000	P=0.298	P=0.213
Y14	0.0944	0.0251	-0.1279	-0.0595	0.0122	0.0660	0.0871	0.0666	-0.1030	0.0054
	(433)	(429)	(432)	(427)	(428)	(422)	(436)	(432)	(429)	(433)
	P=0.025	P=0.302	P=0.004	P=0.110	P=0.401	P=0.088	P=0.035	P=0.083	P=0.016	P=0.455
Y15	0.1253	0.0070	-0.0678	-0.0185	0.0463	0.0321	0.1315	0.0528	0.0179	-0.0534
	(442)	(439)	(441)	(436)	(437)	(430)	(444)	(440)	(436)	(441)
	P=0.004	P=0.442	P=0.077	P=0.350	P=0.167	P=0.253	P=0.003	P=0.135	P=0.355	P=0.132
Y16	0.1171	0.1408	-0.0391	0.0345	0.0420	0.1057	0.1243	0.0401	0.0965	-0.0418
	(448)	(444)	(447)	(442)	(443)	(436)	(450)	(446)	(441)	(447)
	P=0.007	P=0.001	P=0.205	P=0.235	P=0.189	P=0.014	P=0.004	P=0.199	P=0.021	P=0.189
Y17	0.1813	0.1511	0.0823	0.0854	0.0454	0.1814	0.1512	0.0840	0.0937	0.1547
	(443)	(439)	(442)	(437)	(438)	(431)	(445)	(441)	(436)	(442)
	P=0.000	P=0.001	P=0.042	P=0.037	P=0.172	P=0.000	P=0.001	P=0.039	P=0.025	P=0.001
Y18	0.0944	0.1189	0.0693	0.0603	0.0867	0.1128	0.0923	0.0872	-0.0463	0.0391
	(441)	(437)	(440)	(436)	(437)	(430)	(443)	(439)	(436)	(440)
	P=0.024	P=0.006	P=0.073	P=0.105	P=0.035	P=0.010	P=0.026	P=0.034	P=0.167	P=0.207
Y19	-0.2836	-0.2506	0.0186	-0.0885	-0.1490	-0.1672	-0.3608	-0.1513	-0.1377	-0.1813
	(436)	(433)	(435)	(431)	(432)	(424)	(437)	(434)	(430)	(435)
	P=0.000	P=0.000	P=0.349	P=0.033	P=0.001	P=0.000	P=0.000	P=0.001	P=0.002	P=0.000

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SUBFILE NC NW SE WC LR SC NE

PEARSON CORRELATION COEFFICIENTS

	X11	X12	X13	X14	X15	X16	X17	X18	X19	X20
X32	0.4474	0.4603	0.0586	0.4639	0.5321	0.5362	0.4098	0.3067	0.5499	0.3156
	(457)	(453)	(456)	(451)	(452)	(445)	(459)	(455)	(450)	(456)
	P=0.000	P=0.000	P=0.106	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000
X31	0.4879	0.4700	0.0458	0.4669	0.5662	0.5557	0.5194	0.3454	0.5531	0.3293
	(457)	(453)	(456)	(451)	(452)	(445)	(459)	(455)	(450)	(456)
	P=0.000	P=0.000	P=0.164	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000	P=0.000
Y30	0.0384	0.0943	-0.0548	-0.0484	-0.0343	0.0612	0.0236	0.0859	-0.0884	-0.0223
	(449)	(445)	(448)	(443)	(444)	(437)	(451)	(447)	(442)	(448)
	P=0.209	P=0.023	P=0.124	P=0.155	P=0.235	P=0.101	P=0.309	P=0.035	P=0.032	P=0.319
Y31	0.1084	-0.0048	-0.0290	0.0269	0.0711	0.0166	0.1379	0.1233	0.0693	-0.0061
	(433)	(429)	(432)	(427)	(428)	(422)	(436)	(432)	(429)	(433)
	P=0.012	P=0.460	P=0.274	P=0.290	P=0.071	P=0.367	P=0.002	P=0.005	P=0.076	P=0.450
Y32	0.0977	-0.1630	-0.1304	-0.0531	0.0414	-0.0374	0.0365	0.0470	-0.0061	-0.0552
	(429)	(425)	(429)	(424)	(424)	(417)	(431)	(429)	(422)	(428)
	P=0.022	P=0.000	P=0.003	P=0.138	P=0.197	P=0.223	P=0.225	P=0.165	P=0.450	P=0.127

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SUBFILE NC NW SE WC LR SC NE

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	Y6	Y7	Y8	Y9	Y10	Y12	Y13	Y14	Y15	Y16
X1	0.0267	-0.0279	0.0955	0.0116	0.0510	0.0984	0.0106	-0.0307	0.0279	0.0106
	(457)	(453)	(448)	(451)	(457)	(458)	(456)	(439)	(449)	(455)
	P=0.285	P=0.277	P=0.022	P=0.403	P=0.138	P=0.018	P=0.410	P=0.261	P=0.278	P=0.411
X2	-0.0603	-0.0987	-0.0134	0.0443	-0.0262	-0.0888	-0.0288	0.0106	-0.0252	0.0687
	(455)	(451)	(446)	(449)	(455)	(456)	(454)	(437)	(447)	(453)
	P=0.100	P=0.018	P=0.389	P=0.175	P=0.289	P=0.029	P=0.270	P=0.412	P=0.297	P=0.072
X3	0.1151	-0.0392	0.0787	0.0528	0.0075	-0.0019	0.0224	0.0670	0.0893	0.0285
	(458)	(454)	(449)	(452)	(458)	(459)	(457)	(440)	(450)	(456)
	P=0.007	P=0.202	P=0.048	P=0.131	P=0.437	P=0.484	P=0.317	P=0.080	P=0.029	P=0.272
X4	-0.0509	-0.0971	0.1410	0.0207	0.0034	0.0060	-0.0242	-0.0250	0.0729	0.0933
	(449)	(445)	(440)	(444)	(449)	(450)	(448)	(431)	(441)	(447)
	P=0.141	P=0.020	P=0.002	P=0.332	P=0.472	P=0.450	P=0.305	P=0.302	P=0.063	P=0.024
X5	0.1112	-0.1997	0.1716	0.0770	-0.0938	0.0065	0.0650	-0.0613	0.0059	0.0823
	(457)	(453)	(448)	(451)	(457)	(458)	(456)	(439)	(449)	(455)
	P=0.009	P=0.000	P=0.000	P=0.051	P=0.023	P=0.445	P=0.083	P=0.100	P=0.450	P=0.040
X6	-0.1048	-0.1418	-0.0487	0.0379	-0.0430	-0.0769	-0.0166	-0.1385	-0.1360	-0.0008
	(456)	(452)	(447)	(450)	(456)	(457)	(455)	(438)	(448)	(454)
	P=0.013	P=0.001	P=0.152	P=0.211	P=0.180	P=0.050	P=0.362	P=0.002	P=0.002	P=0.493
X7	0.1206	0.0474	0.2338	0.0747	0.0781	0.0581	0.0266	0.0573	0.1006	0.1052
	(456)	(452)	(447)	(450)	(456)	(457)	(455)	(438)	(448)	(454)
	P=0.005	P=0.157	P=0.000	P=0.057	P=0.048	P=0.108	P=0.286	P=0.116	P=0.017	P=0.013
X8	-0.0346	-0.0367	0.1789	0.1132	0.0593	0.0077	0.0487	-0.0332	0.0323	0.0828
	(448)	(445)	(439)	(442)	(448)	(448)	(446)	(430)	(439)	(445)
	P=0.232	P=0.220	P=0.000	P=0.009	P=0.105	P=0.436	P=0.152	P=0.246	P=0.250	P=0.040
X9	0.0371	-0.0001	-0.0264	0.0140	-0.0207	-0.0601	0.0375	0.0445	0.0528	0.0208
	(451)	(447)	(442)	(445)	(451)	(451)	(449)	(433)	(442)	(448)
	P=0.216	P=0.499	P=0.290	P=0.384	P=0.331	P=0.101	P=0.214	P=0.178	P=0.134	P=0.330
X10	-0.0199	-0.0426	0.1766	-0.0613	0.0613	0.0272	-0.0768	-0.0394	-0.0369	0.0563
	(450)	(446)	(441)	(444)	(450)	(450)	(448)	(432)	(441)	(447)
	P=0.337	P=0.185	P=0.000	P=0.099	P=0.097	P=0.282	P=0.052	P=0.207	P=0.220	P=0.117
X11	0.0594	0.0510	0.1654	-0.0011	0.0173	-0.0291	0.0641	0.0944	0.1253	0.1171
	(451)	(447)	(442)	(445)	(451)	(451)	(449)	(433)	(442)	(448)
	P=0.104	P=0.141	P=0.000	P=0.491	P=0.357	P=0.269	P=0.088	P=0.025	P=0.004	P=0.007

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SUBFILE NC NW SE WC LR SC NE

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	Y6	Y7	Y8	Y9	Y10	Y12	Y13	Y14	Y15	Y16
X12	0.0128	-0.0387	-0.1156	-0.0198	-0.0198	0.0280	0.1169	0.0251	0.0070	0.1408
	(447)	(443)	(438)	(441)	(447)	(447)	(445)	(429)	(439)	(444)
	P=0.394	P=0.208	P=0.008	P=0.148	P=0.338	P=0.278	P=0.007	P=0.302	P=0.442	P=0.001
X13	-0.1028	-0.0171	0.0195	0.0936	-0.0392	0.0256	-0.0751	-0.1279	-0.0678	-0.0391
	(450)	(446)	(441)	(444)	(450)	(450)	(448)	(432)	(441)	(447)
	P=0.015	P=0.360	P=0.341	P=0.024	P=0.203	P=0.294	P=0.056	P=0.004	P=0.077	P=0.205
X14	-0.0161	0.0079	0.0441	0.0284	0.0201	-0.0133	0.0069	-0.0595	-0.0185	0.0345
	(445)	(441)	(436)	(439)	(445)	(445)	(443)	(427)	(436)	(442)
	P=0.368	P=0.434	P=0.179	P=0.277	P=0.336	P=0.390	P=0.442	P=0.110	P=0.350	P=0.235
X15	-0.0241	-0.0739	0.1761	0.1965	0.0299	-0.0262	-0.0025	0.0122	0.0463	0.0420
	(446)	(443)	(437)	(440)	(446)	(446)	(444)	(428)	(437)	(443)
	P=0.306	P=0.060	P=0.000	P=0.000	P=0.264	P=0.290	P=0.479	P=0.401	P=0.167	P=0.189
X16	-0.0215	-0.0230	-0.0205	0.0272	-0.0121	-0.0081	0.0430	0.0660	0.0321	0.1057
	(444)	(441)	(435)	(438)	(444)	(439)	(437)	(422)	(430)	(436)
	P=0.326	P=0.315	P=0.335	P=0.285	P=0.399	P=0.433	P=0.185	P=0.088	P=0.253	P=0.014
X17	0.0766	0.0359	0.0776	-0.0109	0.0439	-0.0275	0.0622	0.0871	0.1315	0.1243
	(458)	(454)	(449)	(452)	(458)	(453)	(451)	(436)	(444)	(450)
	P=0.051	P=0.223	P=0.050	P=0.408	P=0.174	P=0.280	P=0.094	P=0.035	P=0.003	P=0.004
X18	0.1001	-0.0007	0.1176	-0.0345	0.0069	-0.0855	0.1819	0.0666	0.0528	0.0401
	(454)	(450)	(445)	(448)	(454)	(449)	(447)	(432)	(440)	(446)
	P=0.017	P=0.494	P=0.007	P=0.233	P=0.442	P=0.035	P=0.000	P=0.083	P=0.135	P=0.199
X19	-0.0398	-0.0638	0.0496	0.0645	-0.0293	-0.1353	-0.0253	-0.1030	0.0179	0.0965
	(449)	(445)	(440)	(444)	(449)	(444)	(442)	(429)	(436)	(441)
	P=0.200	P=0.089	P=0.150	P=0.087	P=0.268	P=0.002	P=0.298	P=0.016	P=0.355	P=0.021
X20	-0.0423	-0.0944	-0.0300	0.0803	0.0327	0.0342	-0.0377	0.0054	-0.0534	-0.0418
	(455)	(451)	(446)	(450)	(455)	(450)	(448)	(433)	(441)	(447)
	P=0.184	P=0.023	P=0.263	P=0.044	P=0.244	P=0.235	P=0.213	P=0.455	P=0.132	P=0.189
Y6	1.0000	0.0902	0.1000	0.0205	0.0954	0.0715	0.0101	0.1953	0.2980	0.0736
	(458)	(453)	(448)	(451)	(457)	(452)	(450)	(435)	(443)	(449)
	P=*****	P=0.028	P=0.017	P=0.332	P=0.021	P=0.065	P=0.416	P=0.000	P=0.000	P=0.060
Y7	0.0902	1.0000	0.0532	0.0405	0.3399	0.0807	-0.0082	0.0558	0.0857	0.1367
	(453)	(454)	(447)	(449)	(454)	(450)	(448)	(433)	(441)	(446)
	P=0.028	P=*****	P=0.131	P=0.196	P=0.000	P=0.044	P=0.431	P=0.123	P=0.036	P=0.002

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PEARSON CORRELATION COEFFICIENTS

	Y6	Y7	Y8	Y9	Y10	Y12	Y13	Y14	Y15	Y16
Y8	0.1000	0.0532	1.0000	0.1510	0.1049	-0.0557	-0.0101	0.0221	0.1181	-0.0090
	(448)	(447)	(449)	(443)	(449)	(444)	(442)	(427)	(435)	(441)
	P=0.017	P=0.131	P=*****	P=0.001	P=0.013	P=0.121	P=0.416	P=0.324	P=0.007	P=0.425
Y9	0.0205	0.0405	0.1510	1.0000	0.0604	-0.0316	-0.0598	0.0355	0.0739	0.0046
	(451)	(449)	(443)	(452)	(452)	(448)	(446)	(433)	(440)	(444)
	P=0.332	P=0.196	P=0.001	P=*****	P=0.100	P=0.252	P=0.104	P=0.230	P=0.061	P=0.462
Y10	0.0954	0.3399	0.1049	0.0604	1.0000	0.0795	-0.1186	0.1319	0.1599	0.0667
	(457)	(454)	(449)	(452)	(458)	(453)	(451)	(436)	(444)	(450)
	P=0.021	P=0.000	P=0.013	P=0.100	P=*****	P=0.046	P=0.006	P=0.003	P=0.000	P=0.079
Y12	0.0715	0.0807	-0.0557	-0.0316	0.0795	1.0000	0.1498	0.1454	0.0006	0.1019
	(452)	(450)	(444)	(448)	(453)	(459)	(457)	(440)	(450)	(455)
	P=0.065	P=0.044	P=0.121	P=0.252	P=0.046	P=*****	P=0.001	P=0.001	P=0.495	P=0.015
Y13	0.0101	-0.0082	-0.0101	-0.0598	-0.1186	0.1498	1.0000	-0.0010	0.0607	0.1635
	(450)	(448)	(442)	(446)	(451)	(457)	(457)	(438)	(449)	(453)
	P=0.416	P=0.431	P=0.416	P=0.104	P=0.006	P=0.001	P=*****	P=0.491	P=0.100	P=0.000
Y14	0.1953	0.0558	0.0221	0.0355	0.1319	0.1454	-0.0010	1.0000	0.2955	0.0163
	(435)	(433)	(427)	(433)	(436)	(440)	(438)	(440)	(432)	(436)
	P=0.000	P=0.123	P=0.324	P=0.230	P=0.003	P=0.001	P=0.491	P=*****	P=0.000	P=0.368
Y15	0.2980	0.0857	0.1181	0.0739	0.1599	0.0006	0.0607	0.2955	1.0000	0.1245
	(443)	(441)	(435)	(440)	(444)	(450)	(449)	(432)	(450)	(447)
	P=0.000	P=0.036	P=0.007	P=0.061	P=0.000	P=0.495	P=0.100	P=0.000	P=*****	P=0.004
Y16	0.0736	0.1367	-0.0090	0.0046	0.0667	0.1019	0.1635	0.0163	0.1245	1.0000
	(449)	(446)	(441)	(444)	(450)	(455)	(453)	(436)	(447)	(456)
	P=0.060	P=0.002	P=0.425	P=0.462	P=0.079	P=0.015	P=0.000	P=0.368	P=0.004	P=*****
Y17	0.0378	-0.0142	-0.0458	-0.0682	0.0046	0.0714	0.0736	0.0329	0.0944	0.1942
	(444)	(441)	(436)	(439)	(445)	(450)	(449)	(431)	(444)	(448)
	P=0.213	P=0.383	P=0.170	P=0.077	P=0.462	P=0.065	P=0.060	P=0.248	P=0.023	P=0.000
Y18	-0.0759	-0.0001	0.0066	-0.0719	0.0160	0.0578	0.2375	-0.1004	-0.0407	0.2180
	(442)	(439)	(434)	(437)	(443)	(448)	(447)	(430)	(442)	(446)
	P=0.056	P=0.499	P=0.445	P=0.067	P=0.369	P=0.111	P=0.000	P=0.019	P=0.197	P=0.000
Y19	-0.0876	0.0112	-0.1488	-0.0533	-0.0555	0.0124	-0.0102	-0.0560	-0.0732	-0.1035
	(436)	(433)	(429)	(432)	(437)	(442)	(441)	(424)	(437)	(440)
	P=0.034	P=0.408	P=0.001	P=0.135	P=0.124	P=0.397	P=0.416	P=0.125	P=0.063	P=0.015

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PROGRAM FOR ALL SUBFILES 04/13/83 PAGE 20

FILE CLIENT (CREATION DATE = 04/13/83)

SUBFILE NC NW SE WC LR SC NE

PEARSON CORRELATION COEFFICIENTS

	Y6	Y7	Y8	Y9	Y10	Y12	Y13	Y14	Y15	Y16
X32	-0.0215	-0.0993	0.1434	0.1115	-0.0064	-0.0367	0.0738	-0.0272	0.0520	0.1369
	(458)	(454)	(449)	(452)	(458)	(458)	(456)	(440)	(449)	(455)
	P=0.323	P=0.017	P=0.001	P=0.009	P=0.445	P=0.217	P=0.058	P=0.285	P=0.136	P=0.002
X31	0.0158	-0.1112	0.1801	0.0944	0.0200	-0.0170	0.0368	-0.0156	0.0529	0.1336
	(458)	(454)	(449)	(452)	(458)	(458)	(456)	(440)	(449)	(455)
	P=0.368	P=0.009	P=0.000	P=0.022	P=0.335	P=0.358	P=0.217	P=0.372	P=0.132	P=0.002
Y30	0.0564	0.0154	-0.0372	-0.0632	-0.0569	0.5796	0.7664	0.0640	0.0627	0.1453
	(450)	(448)	(442)	(446)	(451)	(457)	(457)	(438)	(449)	(453)
	P=0.116	P=0.373	P=0.218	P=0.091	P=0.114	P=0.000	P=0.000	P=0.091	P=0.092	P=0.001
Y31	0.3655	0.0966	0.1414	0.0333	0.1321	0.0726	0.0814	0.3603	0.7488	0.1095
	(435)	(433)	(427)	(433)	(436)	(440)	(438)	(440)	(432)	(436)
	P=0.000	P=0.022	P=0.002	P=0.245	P=0.003	P=0.064	P=0.044	P=0.000	P=0.000	P=0.011
Y32	0.1863	0.1374	0.4430	0.0014	0.1606	-0.0013	-0.0631	0.0910	0.1831	0.0190
	(430)	(428)	(423)	(426)	(431)	(436)	(434)	(419)	(428)	(432)
	P=0.000	P=0.002	P=0.000	P=0.489	P=0.000	P=0.489	P=0.095	P=0.031	P=0.000	P=0.347

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FILE CLIENT (CREATION DATE = 04/13/83)

SUBFILE NC NW SE WC LR SC NE

PEARSON CORRELATION COEFFICIENTS

	Y17	Y18	Y19	X32	X31	Y30	Y31	Y32
X1	0.0618	0.0175	-0.2035	0.2542	0.2425	0.0627	-0.0114	0.0239
	(450)	(448)	(442)	(463)	(463)	(456)	(439)	(435)
	P=0.095	P=0.356	P=0.000	P=0.000	P=0.000	P=0.091	P=0.406	P=0.310
X2	0.0994	0.1407	-0.2129	0.4161	0.4599	-0.1026	0.0250	-0.0991
	(448)	(446)	(441)	(461)	(461)	(454)	(437)	(433)
	P=0.018	P=0.001	P=0.000	P=0.000	P=0.000	P=0.014	P=0.301	P=0.020
X3	0.1292	0.0545	-0.1722	0.3363	0.3950	0.0049	0.0619	0.0328
	(451)	(449)	(443)	(464)	(464)	(457)	(440)	(436)
	P=0.003	P=0.124	P=0.000	P=0.000	P=0.000	P=0.458	P=0.097	P=0.247
X4	0.1123	-0.0165	-0.1173	0.5563	0.5787	-0.0021	0.1094	0.0418
	(442)	(440)	(435)	(455)	(455)	(448)	(431)	(427)
	P=0.009	P=0.365	P=0.007	P=0.000	P=0.000	P=0.482	P=0.012	P=0.194
X5	0.0078	0.0850	-0.2289	0.4510	0.4812	0.0222	-0.0022	0.0385
	(450)	(448)	(442)	(463)	(463)	(456)	(439)	(435)
	P=0.434	P=0.036	P=0.000	P=0.000	P=0.000	P=0.318	P=0.482	P=0.212
X6	0.1337	0.0738	-0.1349	0.4137	0.4640	-0.0494	-0.0679	-0.1265
	(449)	(448)	(441)	(462)	(462)	(455)	(438)	(434)
	P=0.002	P=0.059	P=0.002	P=0.000	P=0.000	P=0.146	P=0.078	P=0.004
X7	0.1629	0.0932	-0.2231	0.3372	0.4131	0.0770	0.0787	0.1042
	(449)	(447)	(442)	(462)	(462)	(455)	(438)	(434)
	P=0.000	P=0.025	P=0.000	P=0.000	P=0.000	P=0.050	P=0.050	P=0.015
X8	0.0624	-0.0440	-0.2279	0.5814	0.6037	0.0696	0.0713	-0.0118
	(440)	(438)	(434)	(454)	(454)	(446)	(430)	(426)
	P=0.096	P=0.179	P=0.000	P=0.000	P=0.000	P=0.071	P=0.070	P=0.404
X9	-0.0065	-0.0057	-0.1856	0.2736	0.2986	0.0103	0.0231	-0.0247
	(443)	(441)	(436)	(457)	(457)	(449)	(433)	(429)
	P=0.446	P=0.453	P=0.000	P=0.000	P=0.000	P=0.414	P=0.316	P=0.305
X10	0.1808	0.0486	-0.1908	0.3088	0.3301	-0.0437	-0.0593	0.1889
	(443)	(440)	(435)	(456)	(456)	(448)	(432)	(428)
	P=0.000	P=0.155	P=0.000	P=0.000	P=0.000	P=0.178	P=0.109	P=0.000
X11	0.1813	0.0944	-0.2836	0.4474	0.4879	0.0384	0.1084	0.0977
	(443)	(441)	(436)	(457)	(457)	(449)	(433)	(429)
	P=0.000	P=0.024	P=0.000	P=0.000	P=0.000	P=0.209	P=0.012	P=0.022

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FILE CLIENT (CREATION DATE = 04/13/83)

SUBFILE NC NW SE WC LR SC NE

PEARSON CORRELATION COEFFICIENTS

	Y17	Y18	Y19	X32	X31	Y30	Y31	Y32
X12	0.1511	0.1189	-0.2506	0.4603	0.4700	0.0943	-0.0048	-0.1630
	(439)	(437)	(433)	(453)	(453)	(445)	(429)	(425)
	P=0.001	P=0.006	P=0.000	P=0.000	P=0.000	P=0.023	P=0.460	P=0.000
X13	0.0823	0.0693	0.0186	0.0586	0.0458	-0.0548	-0.0290	-0.1304
	(442)	(440)	(435)	(456)	(456)	(448)	(432)	(429)
	P=0.042	P=0.073	P=0.349	P=0.106	P=0.164	P=0.124	P=0.274	P=0.003
X14	0.0854	0.0603	-0.0885	0.4639	0.4669	-0.0484	0.0269	-0.0531
	(437)	(436)	(431)	(451)	(451)	(443)	(427)	(424)
	P=0.037	P=0.105	P=0.033	P=0.000	P=0.000	P=0.155	P=0.290	P=0.138
X15	0.0454	0.0867	-0.1490	0.5321	0.5662	-0.0343	0.0711	0.0414
	(438)	(437)	(432)	(452)	(452)	(444)	(428)	(424)
	P=0.172	P=0.035	P=0.001	P=0.000	P=0.000	P=0.235	P=0.071	P=0.197
X16	0.1814	0.1128	-0.1672	0.5362	0.5557	0.0612	0.0166	-0.0374
	(431)	(430)	(424)	(445)	(445)	(437)	(422)	(417)
	P=0.000	P=0.010	P=0.000	P=0.000	P=0.000	P=0.101	P=0.367	P=0.223
X17	0.1512	0.0923	-0.3608	0.4098	0.5194	0.0236	0.1379	0.0365
	(445)	(443)	(437)	(459)	(459)	(451)	(436)	(431)
	P=0.001	P=0.026	P=0.000	P=0.000	P=0.000	P=0.309	P=0.002	P=0.225
X18	0.0840	0.0872	-0.1513	0.3067	0.3454	0.0859	0.1233	0.0470
	(441)	(439)	(434)	(455)	(455)	(447)	(432)	(429)
	P=0.039	P=0.034	P=0.001	P=0.000	P=0.000	P=0.035	P=0.005	P=0.165
X19	0.0937	-0.0463	-0.1377	0.5499	0.5531	-0.0884	0.0693	-0.0061
	(436)	(436)	(430)	(450)	(450)	(442)	(429)	(422)
	P=0.025	P=0.167	P=0.002	P=0.000	P=0.000	P=0.032	P=0.076	P=0.450
X20	0.1547	0.0391	-0.1813	0.3156	0.3293	-0.0223	-0.0061	-0.0552
	(442)	(440)	(435)	(456)	(456)	(448)	(433)	(428)
	P=0.001	P=0.207	P=0.000	P=0.000	P=0.000	P=0.319	P=0.450	P=0.127
Y6	0.0378	-0.0759	-0.0876	-0.0215	0.0158	0.0564	0.3655	0.1863
	(444)	(442)	(436)	(458)	(458)	(450)	(435)	(430)
	P=0.213	P=0.056	P=0.034	P=0.323	P=0.368	P=0.116	P=0.000	P=0.000
Y7	-0.0142	-0.0001	0.0112	-0.0993	-0.1112	0.0154	0.0966	0.1374
	(441)	(439)	(433)	(454)	(454)	(448)	(433)	(428)
	P=0.383	P=0.499	P=0.408	P=0.017	P=0.009	P=0.373	P=0.022	P=0.002

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FILE CLIENT (CREATION DATE = 04/13/83)

SUBFILE NC NW SE WC LR SC NE

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	Y17	Y18	Y19	X32	X31	Y30	Y31	Y32
Y8	-0.0458	0.0066	-0.1488	0.1434	0.1801	-0.0372	0.1414	0.4430
	(436)	(434)	(429)	(449)	(449)	(442)	(427)	(423)
	P=0.170	P=0.445	P=0.001	P=0.001	P=0.000	P=0.218	P=0.002	P=0.000
Y9	-0.0682	-0.0719	-0.0533	0.1115	0.0944	-0.0632	0.0333	0.0014
	(439)	(437)	(432)	(452)	(452)	(446)	(433)	(426)
	P=0.077	P=0.067	P=0.135	P=0.009	P=0.022	P=0.091	P=0.245	P=0.489
Y10	0.0046	0.0160	-0.0555	-0.0064	0.0200	-0.0569	0.1321	0.1606
	(445)	(443)	(437)	(458)	(458)	(451)	(436)	(431)
	P=0.462	P=0.369	P=0.124	P=0.445	P=0.335	P=0.114	P=0.003	P=0.000
Y12	0.0714	0.0578	0.0124	-0.0367	-0.0170	0.5796	0.0726	-0.0013
	(450)	(448)	(442)	(458)	(458)	(457)	(440)	(436)
	P=0.065	P=0.111	P=0.397	P=0.217	P=0.358	P=0.000	P=0.064	P=0.489
Y13	0.0736	0.2375	-0.0102	0.0738	0.0368	0.7664	0.0814	-0.0631
	(449)	(447)	(441)	(456)	(456)	(457)	(438)	(434)
	P=0.060	P=0.000	P=0.416	P=0.058	P=0.217	P=0.000	P=0.044	P=0.095
Y14	0.0329	-0.1004	-0.0560	-0.0272	-0.0156	0.0640	0.3603	0.0910
	(431)	(430)	(424)	(440)	(440)	(438)	(440)	(419)
	P=0.248	P=0.019	P=0.125	P=0.285	P=0.372	P=0.091	P=0.000	P=0.031
Y15	0.0944	-0.0407	-0.0732	0.0520	0.0529	0.0627	0.7488	0.1831
	(444)	(442)	(437)	(449)	(449)	(449)	(432)	(428)
	P=0.023	P=0.197	P=0.063	P=0.136	P=0.132	P=0.092	P=0.000	P=0.000
Y16	0.1942	0.2180	-0.1035	0.1369	0.1336	0.1453	0.1095	0.0190
	(448)	(446)	(440)	(455)	(455)	(453)	(436)	(432)
	P=0.000	P=0.000	P=0.015	P=0.002	P=0.002	P=0.001	P=0.011	P=0.347
Y17	1.0000	0.2531	-0.1200	0.1943	0.2378	0.0822	0.0536	-0.0076
	(451)	(446)	(439)	(450)	(450)	(449)	(431)	(427)
	P=*****	P=0.000	P=0.006	P=0.000	P=0.000	P=0.041	P=0.133	P=0.438
Y18	0.2531	1.0000	0.0126	0.1404	0.1228	0.1745	-0.0576	-0.0296
	(446)	(449)	(437)	(448)	(448)	(447)	(430)	(426)
	P=0.000	P=*****	P=0.396	P=0.001	P=0.005	P=0.000	P=0.117	P=0.271
Y19	-0.1200	0.0126	1.0000	-0.3579	-0.4134	-0.0062	-0.0889	0.0266
	(439)	(437)	(443)	(442)	(442)	(441)	(424)	(421)
	P=0.006	P=0.396	P=*****	P=0.000	P=0.000	P=0.448	P=0.034	P=0.293

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FILE CLIENT (CREATION DATE = 04/13/83)

SUBFILE NC NW SE WC LR SC NE

PEARSON CORRELATION COEFFICIENTS

	Y17	Y18	Y19	X32	X31	Y30	Y31	Y32
X32	0.1943	0.1404	-0.3579	1.0000	0.8801	0.0071	0.0681	-0.0054
	(450)	(448)	(442)	(464)	(464)	(456)	(440)	(435)
	P=0.000	P=0.001	P=0.000	P=*****	P=0.000	P=0.440	P=0.077	P=0.455
X31	0.2378	0.1228	-0.4134	0.8801	1.0000	0.0151	0.0840	-0.0077
	(450)	(448)	(442)	(464)	(464)	(456)	(440)	(435)
	P=0.000	P=0.005	P=0.000	P=0.000	P=*****	P=0.374	P=0.039	P=0.437
Y30	0.0822	0.1745	-0.0062	0.0071	0.0151	1.0000	0.1028	-0.0524
	(449)	(447)	(441)	(456)	(456)	(457)	(438)	(434)
	P=0.041	P=0.000	P=0.448	P=0.440	P=0.374	P=*****	P=0.016	P=0.138
Y31	0.0536	-0.0576	-0.0889	0.0681	0.0840	0.1028	1.0000	0.1250
	(431)	(430)	(424)	(440)	(440)	(438)	(440)	(419)
	P=0.133	P=0.117	P=0.034	P=0.077	P=0.039	P=0.016	P=*****	P=0.005
Y32	-0.0076	-0.0296	0.0266	-0.0054	-0.0077	-0.0524	0.1250	1.0000
	(427)	(426)	(421)	(435)	(435)	(434)	(419)	(436)
	P=0.438	P=0.271	P=0.293	P=0.455	P=0.437	P=0.138	P=0.005	P=*****

(COEFFICIENT / (CASES) / SIGNIFICANCE) (A VALUE OF 99.0000 IS PRINTED IF A COEFFICIENT CANNOT BE COMPUTED)

APPENDIX L

FACTOR ANALYSIS

DETERMINANT OF CORRELATION MATRIX = 0.0117874(0.11787392D-01)
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FILE CLIENT (CREATION DATE = 03/29/83)
SUBFILE NC NW SE WC LR SC NE

VARIABLE	EST COMMUNALITY	FACTOR	EIGENVALUE	PCT OF VAR	CUM PCT
X1	1.00000	1	4.17136	20.9	20.9
X2	1.00000	2	2.84908	14.2	35.1
X3	1.00000	3	1.41694	7.1	42.2
X4	1.00000	4	1.07752	5.4	47.6
X5	1.00000	5	0.99777	5.0	52.6
X6	1.00000	6	0.87468	4.4	56.9
X7	1.00000	7	0.84716	4.2	61.2
X8	1.00000	8	0.80451	4.0	65.2
X9	1.00000	9	0.78493	3.9	69.1
X10	1.00000	10	0.76629	3.8	73.0
X11	1.00000	11	0.68536	3.4	76.4
X12	1.00000	12	0.65622	3.3	79.7
X13	1.00000	13	0.63787	3.2	82.8
X14	1.00000	14	0.58703	2.9	85.8
X15	1.00000	15	0.55130	2.8	88.5
X16	1.00000	16	0.52561	2.6	91.2
X17	1.00000	17	0.49864	2.5	93.7
X18	1.00000	18	0.46321	2.3	96.0
X19	1.00000	19	0.42876	2.1	98.1
X20	1.00000	20	0.37569	1.9	100.0

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FILE CLIENT (CREATION DATE = 03/29/83)
SUBFILE NC NW SE WC LR SC NE

FACTOR MATRIX USING PRINCIPAL FACTOR, NO ITERATIONS

	FACTOR 1	FACTOR 2	FACTOR 3	FACTOR 4
X1	0.14102	-0.02689	0.71172	-0.10980
X2	0.47596	-0.03857	-0.40127	0.30910
X3	0.44156	-0.42744	-0.09002	-0.04150
X4	0.54732	0.39006	0.17345	-0.13677
X5	0.49097	-0.04768	-0.00058	-0.26405
X6	0.40617	0.50191	-0.14093	0.02270
X7	0.37656	0.02174	0.46985	-0.16212
X8	0.57865	0.31889	0.15457	-0.16727
X9	0.33704	-0.51099	-0.17522	0.03645
X10	0.28694	-0.02047	0.24456	0.35089
X11	0.58257	-0.43487	0.04117	0.17773
X12	0.54655	-0.40450	-0.18434	0.10145
X13	-0.08602	0.62020	0.04481	0.37361
X14	0.46770	0.47671	-0.19079	-0.12521
X15	0.51447	0.54710	-0.00188	-0.12298
X16	0.60860	-0.06990	-0.25635	-0.24154
X17	0.59344	-0.44795	0.10962	0.24556
X18	0.39853	-0.39498	0.33228	-0.03505
X19	0.54125	0.40852	-0.19747	0.00597
X20	0.22050	0.31910	0.23449	0.60697

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435
436 FILE   CLIENT   (CREATION DATE = 03/29/83)
437 SUBFILE   NC         NW         SE         WC         LR         SC         NE
438
439
440
441
442 VARIABLE       COMMUNALITY
443
444 X1                0.53920
445 X2                0.48458
446 X3                0.38751
447 X4                0.50050
448 X5                0.31305
449 X6                0.43726
450 X7                0.38932
451 X8                0.48840
452 X9                0.40673
453 X10               0.26569
454 X11               0.56178
455 X12               0.50661
456 X13               0.53365
457 X14               0.49807
458 X15               0.57912
459 X16               0.49933
460 X17               0.62515
461 X18               0.42647
462 X19               0.49888
463 X20               0.57385
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FILE CLIENT (CREATION DATE = 03/29/83)
SUBFILE NC NW SE WC LR SC NE

VARIMAX ROTATED FACTOR MATRIX

	FACTOR 1	FACTOR 2	FACTOR 3	FACTOR 4
X1	-0.02568	-0.02296	0.72487	0.11219
X2	0.46048	0.30009	-0.35722	0.23424
X3	0.60889	0.04986	0.05890	-0.10398
X4	0.04510	0.63559	0.28822	0.10687
X5	0.32862	0.37169	0.18768	-0.17799
X6	-0.05201	0.62998	-0.08993	0.17203
X7	0.13408	0.22810	0.56321	0.04586
X8	0.11550	0.62128	0.29226	0.06044
X9	0.62285	-0.08068	-0.05901	-0.09382
X10	0.21287	0.05416	0.18667	0.42732
X11	0.71610	0.06477	0.14679	0.15247
X12	0.69952	0.11951	-0.04993	0.02238
X13	-0.45179	0.24900	-0.13762	0.49859
X14	-0.00423	0.70102	-0.07705	0.02612
X15	-0.05508	0.74467	0.10183	0.10577
X16	0.47144	0.47914	-0.02880	-0.21603
X17	0.72990	0.03466	0.19358	0.23177
X18	0.48390	-0.03677	0.43649	0.02084
X19	0.11246	0.67606	-0.10061	0.13801
X20	-0.03444	0.17086	0.05981	0.73477

TRANSFORMATION MATRIX

	FACTOR 1	FACTOR 2	FACTOR 3	FACTOR 4
FACTOR 1	0.67408	0.68929	0.21645	0.15379
FACTOR 2	-0.70449	0.65740	-0.08069	0.25497
FACTOR 3	-0.17521	-0.18169	0.92691	0.27771
FACTOR 4	0.13644	-0.24433	-0.29575	0.91336

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