Running Head: BOUNDARY PRACTICES OF PSYCHIATRIC NURSES

The Incidence of Potential Boundary Violation Behaviours of Psychiatric Nurses

By

Bernadine Desender

A Thesis
Submitted to the Faculty of Graduate Studies
In Partial Fulfilment of the Requirements
for the Degree of

MASTER OF EDUCATION

Department of Educational Psychology
University of Manitoba
Winnipeg, Manitoba

ISBN 0-612-16123-4

Canada

Name _____

Dissertation Abstracts International and *Masters Abstracts International* are arranged by broad, general subject categories. Please select the one subject which most nearly describes the content of your dissertation or thesis. Enter the corresponding four-digit code in the spaces provided.

~~PSYCHOLOGY~~ EDUCATION - PSYCHOLOGY 0525 UMI

SUBJECT TERM SUBJECT CODE

Subject Categories

THE HUMANITIES AND SOCIAL SCIENCES

COMMUNICATIONS AND THE ARTS
Architecture 0729
Art History 0377
Cinema 0900
Dance 0378
Fine Arts 0357
Information Science 0723
Journalism 0391
Library Science 0399
Mass Communications 0708
Music 0413
Speech Communication 0459
Theater 0465

EDUCATION
General 0515
Administration 0514
Adult and Continuing 0516
Agricultural 0517
Art 0273
Bilingual and Multicultural 0282
Business 0688
Community College 0275
Curriculum and Instruction 0727
Early Childhood 0518
Elementary 0524
Finance 0277
Guidance and Counseling 0519
Health 0680
Higher 0745
History of 0520
Home Economics 0278
Industrial 0521
Language and Literature 0279
Mathematics 0280
Music 0522
Philosophy of 0998
Physical 0523
Psychology 0525
Reading 0535
Religious 0527
Sciences 0714
Secondary 0533
Social Sciences 0534
Sociology of 0340
Special 0529
Teacher Training 0530
Technology 0710
Tests and Measurements 0288
Vocational 0747

LANGUAGE, LITERATURE AND LINGUISTICS
Language
- General 0679
- Ancient 0289
- Linguistics 0290
- Modern 0291

Literature
- General 0401
- Classical 0294
- Comparative 0295
- Medieval 0297
- Modern 0298
- African 0316
- American 0591
- Asian 0305
- Canadian (English) 0352
- Canadian (French) 0355
- English 0593
- Germanic 0311
- Latin American 0312
- Middle Eastern 0315
- Romance 0313
- Slavic and East European 0314

PHILOSOPHY, RELIGION AND THEOLOGY
Philosophy 0422
Religion
- General 0318
- Biblical Studies 0321
- Clergy 0319
- History of 0320
- Philosophy of 0322

Theology 0469

SOCIAL SCIENCES
American Studies 0323
Anthropology
- Archaeology 0324
- Cultural 0326
- Physical 0327

Business Administration
- General 0310
- Accounting 0272
- Banking 0770
- Management 0454
- Marketing 0338

Canadian Studies 0385
Economics
- General 0501
- Agricultural 0503
- Commerce-Business 0505
- Finance 0508
- History 0509
- Labor 0510
- Theory 0511

Folklore 0358
Geography 0366
Gerontology 0351
History
- General 0578
- Ancient 0579
- Medieval 0581
- Modern 0582
- Black 0328
- African 0331
- Asia, Australia and Oceania 0332
- Canadian 0334
- European 0335
- Latin American 0336
- Middle Eastern 0333
- United States 0337

History of Science 0585
Law 0398
Political Science
- General 0615
- International Law and Relations 0616
- Public Administration 0617

Recreation 0814
Social Work 0452
Sociology
- General 0626
- Criminology and Penology 0627
- Demography 0938
- Ethnic and Racial Studies 0631
- Individual and Family Studies 0628
- Industrial and Labor Relations 0629
- Public and Social Welfare 0630
- Social Structure and Development 0700
- Theory and Methods 0344

Transportation 0709
Urban and Regional Planning 0999
Women's Studies 0453

THE SCIENCES AND ENGINEERING

BIOLOGICAL SCIENCES
Agriculture
- General 0473
- Agronomy 0285
- Animal Culture and Nutrition 0475
- Animal Pathology 0476
- Food Science and Technology 0359
- Forestry and Wildlife 0478
- Plant Culture 0479
- Plant Pathology 0480
- Plant Physiology 0817
- Range Management 0777
- Wood Technology 0746

Biology
- General 0306
- Anatomy 0287
- Biostatistics 0308
- Botany 0309
- Cell 0379
- Ecology 0329
- Entomology 0353
- Genetics 0369
- Limnology 0793
- Microbiology 0410
- Molecular 0307
- Neuroscience 0317
- Oceanography 0416
- Physiology 0433
- Radiation 0821
- Veterinary Science 0778
- Zoology 0472

Biophysics
- General 0786
- Medical 0760

EARTH SCIENCES
Biogeochemistry 0425
Geochemistry 0996
Geodesy 0370
Geology 0372
Geophysics 0373
Hydrology 0388
Mineralogy 0411
Paleobotany 0345
Paleoecology 0426
Paleontology 0418
Paleozoology 0985
Palynology 0427
Physical Geography 0368
Physical Oceanography 0415

HEALTH AND ENVIRONMENTAL SCIENCES
Environmental Sciences 0768
Health Sciences
- General 0566
- Audiology 0300
- Chemotherapy 0992
- Dentistry 0567
- Education 0350
- Hospital Management 0769
- Human Development 0758
- Immunology 0982
- Medicine and Surgery 0564
- Mental Health 0347
- Nursing 0569
- Nutrition 0570
- Obstetrics and Gynecology 0380
- Occupational Health and Therapy 0354
- Ophthalmology 0381
- Pathology 0571
- Pharmacology 0419
- Pharmacy 0572
- Physical Therapy 0382
- Public Health 0573
- Radiology 0574
- Recreation 0575
- Speech Pathology 0460
- Toxicology 0383

Home Economics 0386

PHYSICAL SCIENCES
Pure Sciences
Chemistry
- General 0485
- Agricultural 0749
- Analytical 0486
- Biochemistry 0487
- Inorganic 0488
- Nuclear 0738
- Organic 0490
- Pharmaceutical 0491
- Physical 0494
- Polymer 0495
- Radiation 0754

Mathematics 0405
Physics
- General 0605
- Acoustics 0986
- Astronomy and Astrophysics 0606
- Atmospheric Science 0608
- Atomic 0748
- Electronics and Electricity 0607
- Elementary Particles and High Energy 0798
- Fluid and Plasma 0759
- Molecular 0609
- Nuclear 0610
- Optics 0752
- Radiation 0756
- Solid State 0611

Statistics 0463

Applied Sciences
Applied Mechanics 0346
Computer Science 0984
Engineering
- General 0537
- Aerospace 0538
- Agricultural 0539
- Automotive 0540
- Biomedical 0541
- Chemical 0542
- Civil 0543
- Electronics and Electrical 0544
- Heat and Thermodynamics 0348
- Hydraulic 0545
- Industrial 0546
- Marine 0547
- Materials Science 0794
- Mechanical 0548
- Metallurgy 0743
- Mining 0551
- Nuclear 0552
- Packaging 0549
- Petroleum 0765
- Sanitary and Municipal 0554
- System Science 0790

Geotechnology 0428
Operations Research 0796
Plastics Technology 0795
Textile Technology 0994

PSYCHOLOGY
General 0621
Behavioral 0384
Clinical 0622
Developmental 0620
Experimental 0623
Industrial 0624
Personality 0625
Physiological 0989
Psychobiology 0349
Psychometrics 0632
Social 0451

Nom _____

Dissertation Abstracts International est organisé en catégories de sujets. Veuillez s.v.p. choisir le sujet qui décrit le mieux votre thèse et inscrivez le code numérique approprié dans l'espace réservé ci-dessous.

_____ ☐☐☐ U·M·I

SUJET — CODE DE SUJET

Catégories par sujets

HUMANITÉS ET SCIENCES SOCIALES

COMMUNICATIONS ET LES ARTS
Architecture 0729
Beaux-arts 0357
Bibliothéconomie 0399
Cinéma 0900
Communication verbale 0459
Communications 0708
Danse 0378
Histoire de l'art 0377
Journalisme 0391
Musique 0413
Sciences de l'information 0723
Théâtre 0465

ÉDUCATION
Généralités 515
Administration 0514
Art 0273
Collèges communautaires 0275
Commerce 0688
Économie domestique 0278
Éducation permanente 0516
Éducation préscolaire 0518
Éducation sanitaire 0680
Enseignement agricole 0517
Enseignement bilingue et multiculturel 0282
Enseignement industriel 0521
Enseignement primaire. 0524
Enseignement professionnel 0747
Enseignement religieux 0527
Enseignement secondaire 0533
Enseignement spécial 0529
Enseignement supérieur 0745
Évaluation 0288
Finances 0277
Formation des enseignants 0530
Histoire de l'éducation 0520
Langues et littérature 0279
Lecture 0535
Mathématiques 0280
Musique 0522
Orientation et consultation 0519
Philosophie de l'éducation 0998
Physique 0523
Programmes d'études et enseignement 0727
Psychologie 0525
Sciences 0714
Sciences sociales 0534
Sociologie de l'éducation 0340
Technologie 0710

LANGUE, LITTÉRATURE ET LINGUISTIQUE
Langues
- Généralités 0679
- Anciennes 0289
- Linguistique 0290
- Modernes 0291

Littérature
- Généralités 0401
- Anciennes 0294
- Comparée 0295
- Médiévale 0297
- Moderne 0298
- Africaine 0316
- Américaine 0591
- Anglaise 0593
- Asiatique 0305
- Canadienne (Anglaise) 0352
- Canadienne (Française) 0355
- Germanique 0311
- Latino-américaine 0312
- Moyen-orientale 0315
- Romane 0313
- Slave et est-européenne 0314

PHILOSOPHIE, RELIGION ET THÉOLOGIE
Philosophie 0422
Religion
- Généralités 0318
- Clergé 0319
- Études bibliques 0321
- Histoire des religions 0320
- Philosophie de la religion 0322

Théologie 0469

SCIENCES SOCIALES
Anthropologie
- Archéologie 0324
- Culturelle 0326
- Physique 0327

Droit 0398
Économie
- Généralités 0501
- Commerce-Affaires 0505
- Économie agricole 0503
- Économie du travail 0510
- Finances 0508
- Histoire 0509
- Théorie 0511

Études américaines 0323
Études canadiennes 0385
Études féministes 0453
Folklore 0358
Géographie 0366
Gérontologie 0351
Gestion des affaires
- Généralités 0310
- Administration 0454
- Banques 0770
- Comptabilité 0272
- Marketing 0338

Histoire
- Histoire générale 0578
- Ancienne 0579
- Médiévale 0581
- Moderne 0582
- Histoire des noirs 0328
- Africaine 0331
- Canadienne 0334
- États-Unis 0337
- Européenne 0335
- Moyen-orientale 0333
- Latino-américaine 0336
- Asie, Australie et Océanie 0332

Histoire des sciences 0585
Loisirs 0814
Planification urbaine et régionale 0999
Science politique
- Généralités 0615
- Administration publique 0617
- Droit et relations internationales 0616

Sociologie
- Généralités 0626
- Aide et bien-être social 0630
- Criminologie et établissements pénitentiaires 0627
- Démographie 0938
- Études de l' individu et de la famille 0628
- Études des relations interethniques et des relations raciales 0631
- Structure et développement social 0700
- Théorie et méthodes. 0344
- Travail et relations industrielles 0629

Transports 0709
Travail social 0452

SCIENCES ET INGÉNIERIE

SCIENCES BIOLOGIQUES
Agriculture
- Généralités 0473
- Agronomie. 0285
- Alimentation et technologie alimentaire 0359
- Culture 0479
- Élevage et alimentation 0475
- Exploitation des pâturages 0777
- Pathologie animale 0476
- Pathologie végétale 0480
- Physiologie végétale 0817
- Sylviculture et faune 0478
- Technologie du bois 0746

Biologie
- Généralités 0306
- Anatomie 0287
- Biologie (Statistiques) 0308
- Biologie moléculaire 0307
- Botanique 0309
- Cellule 0379
- Écologie 0329
- Entomologie 0353
- Génétique 0369
- Limnologie 0793
- Microbiologie 0410
- Neurologie 0317
- Océanographie 0416
- Physiologie 0433
- Radiation 0821
- Science vétérinaire 0778
- Zoologie 0472

Biophysique
- Généralités 0786
- Medicale 0760

SCIENCES DE LA TERRE
Biogéochimie 0425
Géochimie 0996
Géodésie 0370
Géographie physique 0368
Géologie 0372
Géophysique 0373
Hydrologie 0388
Minéralogie 0411
Océanographie physique 0415
Paléobotanique 0345
Paléoécologie 0426
Paléontologie 0418
Paléozoologie 0985
Palynologie 0427

SCIENCES DE LA SANTÉ ET DE L'ENVIRONNEMENT
Économie domestique 0386
Sciences de l'environnement 0768
Sciences de la santé
- Généralités 0566
- Administration des hôpitaux 0769
- Alimentation et nutrition 0570
- Audiologie 0300
- Chimiothérapie 0992
- Dentisterie 0567
- Développement humain 0758
- Enseignement 0350
- Immunologie 0982
- Loisirs 0575
- Médecine du travail et thérapie 0354
- Médecine et chirurgie 0564
- Obstétrique et gynécologie 0380
- Ophtalmologie 0381
- Orthophonie 0460
- Pathologie 0571
- Pharmacie 0572
- Pharmacologie 0419
- Physiothérapie 0382
- Radiologie 0574
- Santé mentale 0347
- Santé publique 0573
- Soins infirmiers 0569
- Toxicologie 0383

SCIENCES PHYSIQUES
Sciences Pures
Chimie
- Généralités 0485
- Biochimie 487
- Chimie agricole 0749
- Chimie analytique 0486
- Chimie minérale 0488
- Chimie nucléaire 0738
- Chimie organique 0490
- Chimie pharmaceutique 0491
- Physique 0494
- PolymÈres 0495
- Radiation 0754

Mathématiques 0405
Physique
- Généralités 0605
- Acoustique 0986
- Astronomie et astrophysique 0606
- Électronique et électricité 0607
- Fluides et plasma 0759
- Météorologie 0608
- Optique 0752
- Particules (Physique nucléaire) 0798
- Physique atomique 0748
- Physique de l'état solide 0611
- Physique moléculaire 0609
- Physique nucléaire 0610
- Radiation 0756

Statistiques 0463

Sciences Appliqués Et Technologie
Informatique 0984
Ingénierie
- Généralités 0537
- Agricole 0539
- Automobile 0540
- Biomédicale 0541
- Chaleur et thermodynamique 0348
- Conditionnement (Emballage) 0549
- Génie aérospatial 0538
- Génie chimique 0542
- Génie civil 0543
- Génie électronique et électrique 0544
- Génie industriel 0546
- Génie mécanique 0548
- Génie nucléaire 0552
- Ingénierie des systèmes 0790
- Mécanique navale 0547
- Métallurgie 0743
- Science des matériaux 0794
- Technique du pétrole 0765
- Technique minière 0551
- Techniques sanitaires et municipales 0554
- Technologie hydraulique 0545

Mécanique appliquée 0346
Géotechnologie 0428
Matières plastiques (Technologie) 0795
Recherche opérationnelle 0796
Textiles et tissus (Technologie) 0794

PSYCHOLOGIE
Généralités 0621
Personnalité 0625
Psychobiologie 0349
Psychologie clinique 0622
Psychologie du comportement 0384
Psychologie du développement 0620
Psychologie expérimentale 0623
Psychologie industrielle 0624
Psychologie physiologique 0989
Psychologie sociale 0451
Psychométrie 0632

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

COPYRIGHT PERMISSION

THE INCIDENCE OF POTENTIAL BOUNDARY VIOLATION BEHAVIOURS OF PSYCHIATRIC NURSES

BY

BERNADINE DESENDER

A Thesis/Practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF EDUCATION

ABSTRACT

The purpose of this study was to identify the frequency with which registered psychiatric nurses engaged in specific potential boundary violating behaviours. These behaviours were divided into four indices: social involvement, incidental involvement, financial involvement, and dual roles. Scores were calculated for each index and a total score for each respondent. To determine whether or not a relationship existed between each of the indices and the variables of age, sex, marital status, professional designation, advanced specialization in mental health, number of years in counselling since completing training, client type, primary clinic setting, residence while working at primary clinic setting, feelings of isolation, and numbers of unintentional encounters with current or former clients.

Questionnaires were distributed to 1236 Registered Psychiatric Nurses in Manitoba. A return rate of 14.4% was achieved. Analysis was completed on 165 responses.

In the frequencies of behaviours the results were skewed toward no opportunity and no clients. No respondents reported having intercourse with a current client and only 2 (1.2%) reported having a sexual relationship with a client after termination of therapy.

Crosstabulations were conducted for each of the indices and the total score across the variables of age, sex, marital status, professional designation, advanced specialization in mental health, number of years in counselling since completing training, client type, primary clinic setting, residence while working at primary clinic setting, feelings of isolation, and numbers of unintentional encounters with current or former clients. It was revealed that the greater number of unintentional encounters with current or former clients, the higher the scores on all indices and the total score.

Using one way ANOVAs significant differences in the means were demonstrated for the incidental index scores by age, incidental index scores by years of counselling, financial index scores by primary clinic setting, and unintentional encounters by all four indices and the total score.

This study may suggest some areas for future study in this area. As well it may provide information useful in developing guidelines for nurses about boundary violating behaviours.

ACKNOWLEDGEMENTS

No project such as this is created in isolation. It is with great gratitude that I recognize the assistance of others in this research project. My thesis advisor, Dr. Ray Henjum provided me with encouragement and guidance throughout the process. Dr. Paul Madak provided me with guidance and support throughout this project and my entire master's program. Dr. Zana Lutfiyya provided valuable input as a member of my committee. Mrs. Brenda Herd provided assistance in defining my topic and helping me to narrow the multiple interests I held. I would also like to thank Bruce Tulloch for his statistical assistance.

The Manitoba Association of Registered Psychiatric Nurses (RPNAM) provided mailing costs and assistance with photocopying. A special thank you is extended to Annette Osted, Executive Director of RPNAM, for her support of this study. The board of the RPNAM provided assistance by reviewing my questionnaire and proposal and making valuable suggestions.

Finally I would like to thank my family and friends for their support and encouragement. To my friend , Bill I owe gratitude for his all night computer assistance and personal support when I no longer had the strength to carry on. To Denise, Neil, and Peter whose friendship has

meant a great deal to me through difficult times I am truly thankful. I would like to thank Joanna Bolster for her support and long discussions of assistance and Dr. Theresa George for her support and encouragement. To my mother I owe gratitude for teaching me the value of hard work. I would like to thank my father and my brother for always believing in my abilities.

List of Tables

List of Figures

Table of Contents

CHAPTER I: INTRODUCTION TO THE STUDY

Boundaries are limits that help us to define acceptable behaviour in relationships (Epstein, 1994). Boundary violations are difficult to define because what may be a violation to one client may not necessarily be so for another client (Brown, 1994). In professional client relationships boundaries attempt to control for the existing power imbalance. Therefore, boundary violations occur when helping professionals use their power within the therapeutic relationship to address their own needs, rather than the needs of the client (Peterson, 1992).

The College of Nurses of Ontario's Statement of Philosophy of the nurse-client relationship indicates that "the relationship is therapeutic and based on trust, respect, intimacy and power" (College of Nurses of Ontario, 1995, p. A1). Nurses are trusted because the patient believes that professionals will act in his or her best interest and within the scope of their duties. Respect involves treating clients with dignity and within their own cultural beliefs. The intimacy of the nurse-patient relationship occurs as a result of the physical acts necessary in nursing activities, as well as, intimate conversations that take place in order to better care for the client.

The nurse has power over the client in four ways. First, in the health care environment, the nurse has authority because of a familiarity with the system. As well, the nurse may control much of the client's environment. The second mode of power comes from the nurse having expert knowledge about medical care or the client's case that the client does not possess. Thirdly, the nurse has access to privileged information about the client that would not be available if the nurse-client relationship did not exist. Finally, the nurse has influence over the client because of the three previously indicated forms of power. The result is that the client is in a vulnerable position of having less power in the relationship.

Because nurses are predominately female and have served in a subservient role in the health care system for many years, most would tend to see themselves as victims of power relationships rather than perpetrators (Gallop, 1993). This factor was also suggested by Brown (1988) in her discussion paper about lesbian feminist therapists. Perhaps because of this view of themselves as in a position of minimal power, the nursing research on the study of boundary violations by nurses has not been pursued as rigorously as that by other professions.

Statement of the Problem

There has been empirical investigation of physicians, social workers, and psychologists in the area of boundary violations, but psychiatric nurses are consistently left out of the discussions. Most of the entries in the nursing literature involve case studies and editorials. Educational preparation tends to involve discussions of ethics involving consent, withdrawal of treatment, etc. In the preparation of Registered Psychiatric Nurses, more focus is devoted to the dynamics and ethics of the client-nurse relationship than in the education of registered nurses. Lack of knowledge on the part of nurses could lead to boundary violations that unknowingly result in harm to patients. Thus, the purpose of this study is to identify the frequency with which psychiatric nurses engage in specific behaviours with clients that may result in potential boundary violations. The four types of potential boundary violating behaviours include dual professional roles, financial involvements with clients, social involvements with clients, and incidental involvements with clients. The frequencies of these four types of behaviours will be crosstabulated with demographic variables to determine if a relationship exists between these behaviours and the variables.

Significance of the Problem

In the research of other professions, the incidence of client-therapist sexual relationships has been estimated at several different levels. Most studies reported 7% to 10% of mental health professionals sexually exploit their patients (Simon, 1989). Eighty percent of these were male therapists and female clients. Fifteen percent were female therapists and female clients. Two percent were male therapists abusing male clients. The final two percent consisted of female therapists abusing male clients (Schoener, Milgrom, Gonsiorek, Luepker, & Conroe, 1989). Even though the percentages are small, the unnecessary exploitation of clients by any trusted professional is unacceptable. Boundary violations are harmful to clients, therapists, and the professional community regardless of sexual involvement. It is not the act of sex that creates the damage, but the breach of trust that results in the feelings of betrayal for the client. This breach of trust may occur with or without the act of sex.

Pope (1988) formulated a syndrome called therapist-client sex syndrome listing ten damaging aspects for clients. These include the client experiencing ambivalence in feelings for the therapist, guilt, emptiness and isolation, sexual confusion, impaired

ability to trust, identity and role reversal, emotional lability, suppressed rage, increased suicide risk, and cognitive dysfunction. Others state that the symptoms are similar to those experienced by clients who are sexually abused (Disch, 1989; Lymberis, 1994). The harm done to the client should not necessarily be measured in terms of existence or nonexistence of sexual intercourse. The boundary violations themselves are what causes the injury (Markowitz, 1992; Gafner, & Trudeau, 1988).

The harm to therapists includes not only psychological damage to the perpetrator, but also financial and career losses. Colleagues suffer conflicting feelings, guilt, embarrassment, loyalty issues and safety fears as well as increased workload (Regehr & Glancy, 1995; Zelen, 1985). The professional community loses the trust of the public in their abilities when violations become common knowledge.

Nurses may be at risk for boundary violations because of stresses of single parenting, the need to meet social and emotional needs at work, irregular hours, poor education regarding boundaries, and family histories of codependent behaviour, resulting in difficulties in relationships (Pennington, Gafner, Schilit, & Bechtel, 1993; Gafner, & Trudeau, 1988; Trudeau, & Gafner, 1988). Due to recent downsizing, the stress on the job might increase the risk of boundary violations by nurses.

Because the awareness of nurses may not be as high as that of other professionals, who have more closely examined the area, it is essential that a clear picture of the behaviour of nurses is developed so that preventative measures in the form of educational and employment practice programs might be developed.

Research Question

What is the frequency in which psychiatric nurses engage in behaviours including incidental, social, and financial involvements with clients, and/or dual professional roles that may result in potential boundary violating situations? How are those behaviours related to gender, age, marital status, years of experience, theoretical orientation, client type, area of practice, feelings of isolation, place of residence, and number of unintentional encounters with clients?

Definitions

The therapeutic practices survey (Borys, 1988) operationally defines the potential boundary violating situations by dividing these behaviours into three factors through factor analysis. The first of these, incidental involvements, are defined by behaviours

involving one-time events or special occasions during which therapeutic boundaries were altered at the initiation of the client such as accepting a gift or an invitation to a special occasion. The second, social/financial involvements, is described by questions indicating the involvement of the therapist and the client in extratherapeutic social, financial, or business activities. For example, inviting a client to a personal party or buying a service or product from a client. The final factor, dual professional roles, is defined by items concerning the therapist engaging in a dual role of two professional capacities. One example of this may involve a situation where the therapist is both counsellor and employer. In this situation information obtained in one professional role may affect decisions made in the other professional role.

CHAPTER II: REVIEW OF THE LITERATURE

Personal boundaries are a spatial metaphor that help us define relationships with other beings and objects in the world. They define "where one ends and another begins" and provide a recognition of individuals as separate with their own thoughts, feelings, and behaviours (Epstein, 1994; Barnsteiner & Gillis-Donovan, 1990). The management of boundaries assists in the development of trust in relationships (Epstein, 1994). Professional relationship boundaries "define the expected and accepted psychological and social distance between practitioners and patients. They [boundaries] are derived from ethical treatise, cultural morality, and jurisprudence"(Linklater, & MacDougall, 1993, p. 2569).

Boundaries function to control the differences in power between clients and practitioners (Linklater, & MacDougall, 1993; Peterson, 1992; Pilette, Berck, & Achber, 1995). Because human relationships are complex, it is often difficult to define exactly what behaviour for which client is a boundary violation (Brown, 1994; Epstein, 1994). Perhaps this is the reason why the predominate amount of research in this area has focused on sexual relationships with clients, as almost all professionals see this as inappropriate.

Types of Boundary Violations

The literature studying sexual involvement of professionals and clients indicated that the more serious violation of sexual exploitation begins with minor breaches of treatment boundaries. It begins with personal conversations escalating to nonsexual body contact and social encounters, and finally sexual encounters (Strasburger, Jorgenson, & Sutherland, 1992; Linklater, & MacDougall, 1993; Simon, 1989; Epstein & Simon 1990; Epstein, Simon, & Kay, 1992; Pages, Maxim, & Wasch, 1994).

Peterson (1992) stated that:

> Boundary violations are acts that breach the core intent of the professional-client association. They happen when professionals exploit the relationship to meet personal needs rather than client needs. Changing that fundamental principle undoes the covenant, altering the ethos of care that obliges professionals to place clients' concerns first. In fact, all of the boundaries in a professional-client relationship exist in order to protect this core understanding (p. 75).

Peterson (1992) described four categories of relationship violations that have also been described in similar ways by other authors (Guthiel, & Gabbard, 1993; Linklater, & MacDougall, 1993). The first type of violation is the role reversal. In this situation the client's needs are no longer the focus and the professional's needs are addressed through the relationship. The second violation involves keeping a secret from a client, such as not

telling a client he has cancer at the request of the family. The third type of violation is described as the double bind. This situation puts the client in a conflict of interest situation in which they cannot exercise their right to say no. For example, if the therapist asks the client for a ride downtown because his or her car is not working, the client may be concerned about the implications for the therapeutic relationship if he or she declines. The fourth type of violation is described as the indulgence of personal privilege. This may include using information gained in a therapy session for personal benefit, or pursuing a sexual relationship with a client.

Dual Relationships

One type of boundary violation is dual relationships. Using this concept one can identify how having more than one purpose in a professional client relationship can result in conflict.

> Dual relationships cross the line between the therapeutic relationship and a second relationship, undermining the distinctive nature of the therapeutic relationship, blurring the roles of practitioner and client, and permitting the abuse of power...When a professional relationship shifts to a dual relationship the practitioner's power remains but is not checked by the rules of professional conduct or, in some cases, even acknowledged (Kagle, & Giebelhausen, 1994, p.217).

Nonsexual Boundary Violations

Borys and Pope (1989) divided nonsexual boundary violations into three types. The first involved incidental involvements which are one time events or special occasions where therapeutic boundaries are crossed at the initiation of the client such as attending the wedding of a client. The second type is social/financial involvements. This includes therapist and client contact in social, financial, or business activities occurring on a regular basis. The third type is dual professional roles. This involves the therapist entering into dual roles with a client such as therapist and employer, or therapist and teacher. The items developed in the Borys and Pope study will be used in the present study.

Boundary Management

Codes of Ethics

Codes of ethics assist in boundary maintenance and define standards to safeguard patients by setting limits on the power of professionals (Peterson, 1992). The American Psychological Association prohibits dual relationships with clients especially those of a sexual nature. The time frames suggested for this moratorium on

contact have ranged from one year to life, dependent upon the nature and length of the therapy and whether or not countertransference and transference were resolved. In some U.S. states it has become a felony to engage in a relationship with a current or former client dependent upon the above criteria (Schoener, Milgrom, Gonsiorek, Luepker, & Conroe, 1989; Vasquez, 1991; Rinella & Gertsein, 1994). In Canada no such legislation currently exists. The American Association of Marriage and Family Counsellors also prohibits dual relationships with clients, supervisors, employees and students (Ryder & Hepworth, 1990). The Canadian Guidance and Counselling Association stated that dual relationships are only acceptable when no other alternative is available (Schulz, 1989). The Canadian Association of Social Workers (1994) clearly outlines the prohibition of sexual, financial, or exploitive relationships with clients of any kind. The College of Physicians and Surgeons of Manitoba has a guideline addressing doctor/patient sexual relationships. This guideline indicated that sexual relationships are inappropriate under any circumstances. It also indicated that if a previous social relationship exists, the physician will provide only minor emergency care and for no charge (College of Physicians and Surgeons of Manitoba).

In the nursing profession neither the American

Nurses Association nor the Canadian Nurses Association (CNA) directly address the issue of dual relationships in their codes of ethics (Canadian Nurses Association,1991; Pennington, Gaffer, Schilit, & Bechtel, 1993). The CNA code of ethics implies no sexual contact between professionals and clients through the value of no harm. The Manitoba Association of Registered Nurses (MARN) definition of professional misconduct outlines two areas that may apply to boundaries or dual relationships. These include 1) abuse of a client or health team member verbally, physically, or sexually; and 2) inappropriately using the nurse's professional status for personal gain (MARN, 1994). As these definitions are not part of the code of ethics or the nursing care standards, it is possible that many nurses have never seen them. Currently, the MARN is developing a position paper on boundary issues (personal communication with Irene Crowe, Nursing consultant MARN, January 1996). Perhaps this study will contribute to the development of professional guidelines for nurses.

The Registered Psychiatric Nurses Association of Manitoba (RPNAM) developed a position statement on sexual exploitation and abuse by mental health service providers in 1992. It sets the limit for engaging in a sexual or romantic relationship with a previous client at two years after cessation of services (RPNAM, 1992). No other

policy statements around dual relationships exist.

As evidenced by the above codes of ethics, nursing has chosen to imply the impropriety of boundary violations, at least in certain contexts. While this may appear to be vague and possibly misleading, it still is adequate in a court of law (Regan Report on Nursing Law, 1991).

Ontario Regulations

The College of Nurses of Ontario, in response to provincial legislation amending the Regulated Health Professionals Act, have developed a Statement of Philosophy of the Nurse-Client Relationship as well as detailed expectations of professional behaviours outlining very specific boundaries of professional relationships. These include self disclosure, accepting gifts, use of restraints, interpersonal relationships, and romantic/sexual relationships.

Each Ontario regulated health profession was required to develop a patient relations program including measures for preventing or dealing with professional misconduct of a sexual nature (Gallop, 1993). This act also requires that "any health professional, who has reasonable grounds to believe that a client has been sexually abused by another health professional, to report

this to the college of the alleged abuser" (College of Nurses of Ontario, 1995, p. L11). Reasonable grounds include information from a reliable source or reports from a patient. It is not necessary to investigate whether allegations are true, although rumour and gossip would not be considered reasonable sources (College of Nurses of Ontario, 1995). Mandatory reporting does not occur in all provinces or states and in fact occurs seldom in legislation.

Brown's Approach

Brown (1994) stated that hard and fast concrete rules in the area of boundary violations do not reflect the every day practice needs of feminist therapists and their clients. She identified three myths associated with boundaries. The first is that there is one single approach to the function of boundaries in the therapeutic relationship. This approach is that boundaries function as a set of concrete rules to govern the professional-client relationship. She stated that, in reality, boundaries are as variable as the race, class, culture, setting, and human beings in therapeutic relationships and therefore concrete rules cannot be applied. Second is the myth that we will know a boundary violation when we see one. This may be true for highly abusive behaviours,

but other boundary violations may be more subtle and associated with a specific client or the interpretation of the individuals involved. The final myth indicated by Brown (1994) is that it is possible to never violate boundaries if you follow the concrete rules. She responded to this by stating that, because boundaries are defined the experience of each individual client, a therapist may cross a boundary unintentionally. Brown is careful to indicate that although the client is the authority on whether or not their boundaries have been violated, the ultimate responsibility for boundary maintenance belongs to the therapist, as many clients may be vulnerable and unsure of their boundaries.

Brown (1994) proposed that a more feasible method of boundary management is to understand the characteristics of boundaries. Three characteristics are identified which define boundary violations and are present in most situations in which a client has felt a boundary has been violated. The first characteristic is that the client becomes an object to satisfy the needs of the therapist. For example, if the therapist spends extra time with a client in a social situation, this meets the therapists needs for companionship. Second is that the violation may be an acting out or gratification of the therapist's impulse, such as hugging a client spontaneously. The third characteristic of boundary violations is that the

needs of the therapist become the focus rather than the needs of the client. In this situation, the personal difficulties of the therapist may be discussed rather than those of the client. Because this method of boundary identification has no concrete rules, the therapist is required to analyze situations as they arise. This may result in a set of personal guidelines that can then become useful to the therapist.

Potential Boundary Violating Behaviours

The literature contains identified areas of potential concern in therapeutic relationships. The following section will attempt to clarify some of the literature in this area.

Gift Giving

Small gifts (under ten dollars) may not cause harm and in some cases may even be beneficial for clients, especially when given at termination of therapy. Gifts received frequently in a long term therapeutic relationship should be discussed in order to identify the client's purpose in giving (Epstein, 1994; Simon, 1992).

Epstein (1994) stated that large gifts (worth fifty dollars) should be refused, but, therapy should address

why the client feels a need to give such a large gift. A large gift may be a clients means of purchasing, controlling or manipulating the therapist, all of which could be detrimental to treatment.

Morse (1989) studied gift giving in the patient-nurse relationship. Through unstructured interviews Morse found gift giving in the hospital was common and followed a specific pattern. Gifts were most often given for specific occasions or at the end of treatment. Nurses reported that they were comfortable accepting gifts of five dollars, but the greater the value of the gift the more discomfort was expressed at accepting it. Whether or not the gift was to be shared with other nurses was deemed to be a function of the nature of the gift, and the circumstances under which it was given.

Timing of the presentation of the gift was a factor in whether or not the nurse accepted it. Gifts given too early in treatment were seen as bribes.

The final factor considered was whether or not a hidden agenda existed for the acceptance of the gift. Invitations to dinner by male clients after release and personal gift items such as perfume and intimate apparel were usually refused.

Epstein (1994) stated that "just as the patient feels obligated to the nurse for the care received, so does the reciprocal gift carry the possibility of

deflecting impartiality." Morse (1989) summarized by stating that the giving of a gift may be an attempt to balance out the relationship as the patient does not directly pay the nurse for their service. This may be applicable especially, in a country with socialized medicine. Based on these two conflicting points, it is important that the giving and receiving of gifts be carefully examined to identify the purpose of such a gesture.

Social Invitations

Acceptance of social invitations by the therapist can blur the boundaries between personal and social roles. Often social invitations should be refused (Epstein, 1994). Social contact between patient and therapist is often the beginning of further boundary violating behaviours that may end in a sexual relationship (Simon, 1989).

Bartering

Epstein (1994) indicated that the use of barter in therapy is difficult because goods do not have a standardized value. Barter may result in one of the parties feeling exploited. Exchange of therapy for

services, may occur with an increasingly personal involvement of client and therapist. As noted in the previous section this may be the first phase of the "slippery slope" (Simon, 1989).

Posttermination Relationships

Developing a relationship with a client after termination of therapy can be difficult. It requires knowing that therapy was not terminated early to develop the relationship, and that transference issues have been resolved (Schoener et al, 1989). If a therapist and client develop a posttermination relationship, the client can no longer return for therapy should a future need arise. If a hospital nurse develops a relationship with a client, the client may feel unable to return to the facility for assistance. This is harmful to clients because one of their resources is no longer accessible to them.

Financial Involvements

This may include purchasing from or selling a product to a client, borrowing money from a client, hiring a client to perform a service or using "insider" information for financial gain. A client may find it

difficult to refuse the therapist because of a fear that it will affect the therapeutic relationship or because of a desire to please the therapist. Also therapists may feel uncomfortable in recalling the former client to repeat the service if it is not done to satisfaction (Epstein, 1994; Simon, 1989; Peterson, 1992).

Dual Professional Relationships

As previously defined, a dual professional relationship exists when more than one professional relationship is present between the therapist and client. The harm in this type of relationship is that the power of the therapist extends into the other professional relationship or the objectives of the second relationship are not compatible with doing therapy. The client may not feel that honest self disclosure is possible because of a fear of repercussions in the other relationship.

Gartrell, Herman, Olarte, Localio, and Feldstein (1988) conducted a national survey of psychiatric residents to identify the incidence of sexual involvement between residents and their educators or patients. Out of 548 respondents 4.9% indicated that they had been sexually involved with psychiatric educators. The majority of the respondents felt that a sexual relationship between a resident and an educator was

inappropriate and harmful to the working relationship. Most respondents did feel, however, that if a working relationship did not exist, sexual contact could be appropriate.

Borys and Pope (1989) studied dual relationships in psychologists, psychiatrists, and social workers. Eight hundred male and eight hundred female respondents from each profession were sent a questionnaire to assess behaviours and beliefs regarding dual relationships and incidental involvements. One half of respondents were sent a practices survey to indicate behaviours. The other half were sent a similar form assessing beliefs. Demographic variables assessed included gender, profession, age, experience, region of residence, marital status, theoretical orientation, practice setting, and client population.

The response rate was 49%. Results indicated that there were no significant differences among the professions in terms of sexual intimacies with clients, before or after termination, nonsexual dual professional roles, social involvements, or financial involvements with patients. The gender differences that have been found to exist in sexualized dual relationships also exist in nonsexual dual relationships. Male therapists engage more frequently in nonsexual dual relationships with female clients than with male clients. This was

consistent across the three professions.

Self-Disclosure

Disclosure of personal information is strongly discouraged in psychoanalytic views, while the appropriate use of self disclosure is encouraged in humanistic views. Brown (1994) stated that it is not the self-disclosure that is a problem, but the purpose for which the information is being shared. If the purpose is to provide useful information in the context of therapy, no boundary is violated, but, if the purpose is to address the needs of the therapist, then it is inappropriate. Smith-Ramsdell and Ramsdell (1993) found that clients reported therapist self-disclosure to be beneficial in therapy.

Sexual Relationships

The majority of the research in this area focuses on sexual boundary violations. Medical doctors' sexual relationships with clients (White, Coverdale, & Thomson, 1994), mental health professionals in Rhode Island and sexual involvement with clients as reported by subsequent therapists (Parsons, & Wincze, 1995), psychiatrists (Gartrell,et al,1986; Epstein, Simon, & Kay, 1992),

physicians attitudes about erotic and nonerotic contact with patients (Kardner, Fuller, & Mensh, 1973), female physicians erotic and nonerotic physical involvement with patients (Perry, 1976), and psychiatric residents sexual contact with educators and patients (Gartrell et al., 1986) have been studied in diverse ways. These studies have used differing methods of evaluation making comparisons between them difficult. Incidence rates for sexual encounters between professionals and clients have been estimated to be 7.1% of male and 3.1% of female psychiatrists (Gartrell et al, 1986); and 5 to 7.2% of physicians (Kardner, Marielle, & Fuller, 1973). Female physicians were found to believe more in nonerotic touching, but fewer believed or engaged in erotic touching than their male counterparts, and none reported sexual intercourse with patients (Perry, 1976).

Parsons and Wincze (1995) surveyed therapists to identify how many were treating patients abused by previous therapists. Twenty six percent reported treating at least one client with a previous sexual relationship with a therapist. During the three year period studied, 37 incidents were reported, but, only one of these was reported to authorities. One hundred and twenty nonsexual boundary violations that were reported in this study included: planned social encounters; altered insurance claims; using drugs with clients; providing therapy to

employees; borrowing money from clients; and using a client's vacation home.

The Women and Mental Health Committee of The Canadian Mental Health Association (CMHA), Manitoba Division (1993) commissioned a study on the incidence of sexual abuse of women by mental health service providers. Although all types of mental health service providers were included, they were not specified in the study. Respondents included 111 women and four men. One hundred and twenty nine incidents of abuse were noted, as thirty one respondents reported being abused by more than one therapist. The types of abuse ranged from inappropriate sexual conversations to rape. Of the 24 women who reported the incident to authorities, only four indicated a satisfactory outcome. The difficulty with this study was that the questionnaires were distributed from the offices of mental health service providers and, therefore, no guarantee of clients receiving the questionnaires was possible.

In the nursing literature only two studies have been documented regarding sexual involvement of nurses and clients. The first study was completed by Nursing '74 journal (1974). A questionnaire was placed in the journal and those receiving the journal were encouraged to respond. Three questions related to sexual activity with clients. One of the difficulties with this survey is

that a self selecting population is being drawn from an already self-selected population, i.e., those nurses subscribing to the journal. This makes it difficult to draw any conclusions about any specific group of nurses. A clear description of the questionnaire and methods of analysis were not revealed making evaluation of the research by the reader difficult.

The second study by Munsat and Riordan (1990), attempted to assess the incidence of staff-patient sexual. The return rate was 57% . A total of 139 suspicions, 384 allegations, and 106 occurrences were noted. No significant relationship was noted between the number of suspicions, allegations, or occurrences and hospital size, ownership, or the presence of staff education. The limitation of this study is that data was collected from only one person at each hospital for all professions. Other variables such as staffing levels and specifics about the profession of the suspected individual may be useful in future analyses.

Other Factors Associated With Boundary Violations

The research has shown that other factors may affect the potential for boundary violations to occur. In this section the writer will discuss the effects of community size, as well as client and helper characteristics on

boundary violations. A brief discussion of the effects of boundary violations on clients is also present.

Community Size

Living in small rural community increases the number of social contacts between helpers and their clients. "All socioeconomic levels and professions attend the same schools, churches, parent-teacher meetings and social functions" (Sigsby, 1994, p. 534). Often dual social and professional relationships develop out of necessity. Being the "only one" to provide a service may require that services be provided to individuals with whom the helper already has another relationship.

Practising therapy in a small community may lead to several potential areas of conflict for the professional, the therapeutic relationship, and the families of both the therapist and the client (Soreff & Hymoff, 1976). For therapists to continue training and development within their own community may expose them to fears of disclosing personal information to others which may result in loss of status. If a helping professional requires psychiatric treatment in hospital the possibility of being exposed to other colleagues and clients is almost certain.

In terms of the effects on the therapeutic

relationship, both the client and the therapist have extensive knowledge of each other. This can affect anonymity of the therapist and problems in dealing with transference (Soreff & Hymoff, 1976). Role conflicts can occur as a result of dual professional roles. The knowledge or power of the therapist may affect behaviour with the client in another role.

For families of therapists or clients, difficulties can occur in dual relationships or potential problems of confidentiality. Treatment of a therapist's family member can change the role between the therapist and those treating their family from that of colleague to client. Social relationships may be difficult when a client has a social relationship with a therapist's family member. Personal information about the therapist may be revealed unknowingly by the family member to the client. If the therapist tells the family that their friend is a client, confidentiality is breached.

Soreff and Hymoff (1976) believe that benefits of these factors may be that the client and therapist are able to view each other as "more human, more an individual, as a multidimensional, healthy person" (p. 664). The fact that these difficulties exist does not mean that practising in a small community is impossible, just that the therapist must be aware and develop a means of minimizing potential harm.

Characteristics of Helpers

Brodsky (1986) identified the profile of the psychologist most likely to violate boundaries, especially sexual ones. This fictitious individual would be a middle aged male involved in unsatisfactory relationships in his own life. His caseload is primarily female and the clients he becomes involved with are usually 16 years younger. He confides in this client about his personal life and implies he needs her. He is professionally isolated, has a good reputation, and sees clients through referral only. Brodsky (1986) described four types of individuals whose cases come to light regarding sexual relationships with clients. The first is the young therapist who believes he or she is in love with the client. Second are those therapists with personality or other mental disorders. The third is the charismatic professor who charms the unsuspecting student. Finally, there are those who are falsely accused by their clients.

By contrast, the Canada Health Monitor Survey (CNO, 1995) states that the nurse most likely to abuse the patient is a full-time employee, working a day or evening shift, practising for 10 years or less, overworked, tired or stressed due to working conditions and coping with personal problems. The setting is most often a general or

psychiatric hospital or, to a lesser extent, a nursing home. The difference between these presentations of the perpetrator, include the professional background of the perpetrator, the predominant gender in the profession and, as well the types of abuse that have been documented differ significantly (see p. 28 for a discussion of the Canada Health Monitor Survey).

Client Characteristics

The clients abused by psychologists and psychiatrists tend to be female and approximately 16 years younger than the therapist. Schoener et al (1989) stated that of the 2000 clients they have seen who were sexually involved with their therapist, no other consistent characteristics can be identified.

In contrast the Canada Health Monitor Survey (CNO, 1995) found the victims of nurse abuse to generally be a "woman of 65 years or greater, disoriented and/or medicated, in poor but stable condition requiring ongoing treatment, receiving personal care, known to the nurse, and perceived as uncooperative by the nursing staff" (p. A14). Again, these differences may be related to the differences in types of abuse described.

Effects on Clients

As previously noted, Pope defined the therapist-client sex syndrome. The reader is referred to the significance of the problem for a review of the effects of boundary violations on clients.

Smith-Ramsdell and Ramsdell (1993) surveyed 67 former clients of a counselling centre. The former clients were asked to determine whether or not each of 21 behaviours had been beneficial in therapy. Behaviours such as addressing the counsellor by first name, and counsellor sharing personal information were found to be beneficial, while sexual activity, dating, going out socially, and being held or kissed by the therapist were rated as detrimental.

Nursing Literature Pertaining to Boundaries

Case studies of boundary violations, as well as editorial discussions on the topic, assist in describing situations to increase the awareness of professionals. As well, they serve a purpose of identifying patterns in client experiences for further study. Case studies in the literature include difficulties encountered by nurses who try to report abuse of patients (Hicks, 1991); sexual relationships with hospital inpatients (Heywood-Jones,

1990); the murder of a nurse and her grandchildren after the nurse married a psychiatric client (Trudeau & Gaffer, 1988); and a description of a boundary awareness program (Gaffer & Trudeau, 1988).

Menninger (1991) implemented a risk management plan for reporting substandard care at the Menninger Clinic. Twenty four cases of substandard care were reported in 33 months. Twelve of these involved boundary violations by staff toward patients. Seven of the 12 were considered sexual and five were considered nonsexual. Of these seven sexual incidents, four involved male staff and female patients, and three were female staff and male patients. In only three incidents did a direct treatment relationship exist. Of the total 12 incidents, four involved physicians, fives nurses, one mental health technician, one research assistant, and one house keeper.

> Most often, sexual boundary violations involved hospital nursing staff acknowledging attraction and seeking social and or physical contact outside treatment with patients or [a second possibility] a staff member independently meeting a patient in a nontreatment context in the community and becoming sexually involved even after learning that the patient was in active treatment with other staff in the institution (Menninger, 1991, p.676).

The only Canadian study to assess boundary issues in nurses is the Canada Health Monitor commissioned by the College of Nurses of Ontario. A telephone survey was carried out with 804 registered nurses and 804 nursing assistants. The survey asked about the type of abuse, the

setting in which it occurred, the frequency of abuse, professional category of abuser, gender of abuser, client gender, client age, client condition, abuser familiarity with victim, and perceived cause of abuse.

Witnessing of one or more instances of abuse by an RN or RNA was reported by 46% of respondents. The most common types of abuse were: roughness 31%, yelling and swearing 28%, offensive/embarrassing comments 28%, and hitting/shoving 10%. Females were the abusers 86% of the time, although in psychiatric hospitals 35% were male. The perceived causes of the abuse by the respondents included that, 7 out of 10 times, the client was indicated as the primary cause. Responses included: client uncooperative 64%, client abusive 5%, nurse overworked 56%, nurses lack of knowledge or skill 31%, and nurse suffering personal problems 25%. Although this study indicated 46% rate of witnessed abuse, it cannot be used to estimate the number of nurses who have abused clients. As well, this study does not examine more subtle boundary issues such as using information gained from clients for personal financial gain, or using clients to meet personal social needs. These more subtle violations may go unnoticed, but still result in feelings of exploitation for the client.

Nurses have not been included in cross discipline comparisons. Peterson (1992), in her book <u>At Personal</u>

Risk: Boundary Violations in Professional-Client Relationships discusses physicians, clerics, therapists, attorneys, and teachers but no mention is made of nurses. Perhaps, other disciplines do not see nurses as capable of such acts either by lack of power or because of a predominately female gender. Nurses need to be assessed by means that allow comparison to other disciplines. If, as demonstrated in the College of Nurses of Ontario study, abuse is so prevalent, it would be useful to identify nurse behaviours on less obvious boundary violations. Because of nurses' family histories, current problems, and stressful work environment, they are at risk to do significant damage to their clients without even being aware of the dangers.

CHAPTER III: METHOD

In this chapter the writer will define the population of psychiatric nurses to be studied and the specific characteristics known about this group. The data that were collected from respondents is identified and the means of data collection and analysis are outlined.

Population

The population for this study consisted of the active practising membership of the Registered Psychiatric Nurses Association of Manitoba. Each of the 1236 members was sent a copy of the questionnaire along with a demographic sheet and an information sheet. All members of the population were selected to ensure RPNAM confidentiality of their mailing list. This population consisted largely of RPNs, although a small percentage also were Registered Nurses. These nurses have been trained to work specifically in psychiatry with two to three years training.

Approximately 1149 active practising and 87 associate members exist in the RPNAM (Manitoba Nursing Professions Advisory Council (MNPAC), 1995). RPNs consist of 815 (72%) females and 317 (28%) males (MNPAC, 1995). In terms of age, 2.6% of RPNs are less than 25,

24.3% are aged 25 to 34, 36.4% are 35 to 44, and 29.1% are 45 to 54. Sixty nine percent of RPNs are employed full time. Region of residence includes 31.9% in Winnipeg, 67% as rural, and 1.1% as northern (MNPAC, 1995).

The sample was self selecting. Demographic data of respondents was compared with that of the total population of the RPNAM to determine representativeness of the sample. Those members who are no longer active practising service providers only completed the demographic questionnaire to question number six.

Research Instruments

Self report questionnaires have been regarded by researchers as valid sources of obtaining data regarding sensitive issues (Gelles, 1978; Lourie, 1977). For this reason, the writer has chosen to use the Demographic Questionnaire and the Therapeutic Practices Survey developed by Borys (1988). Borys (1988) developed these tools by a review of the literature to identify common demographic factors in professionals who violate boundaries with clients and the types of behaviours found to lead to more serious boundary violations. Peer evaluations of the draft questionnaire provided input for the final product. This questionnaire was developed for

the use of multiple disciplines including psychology, psychiatry, and social work.

Demographic Questionnaire

The Demographic Questionnaire was adapted from Borys' (1988) dissertation at UCLA. The questionnaire asked the respondent to indicate gender, age, marital status, professional designation, any advanced specialization in mental health, and whether or not psychotherapy had been provided in the last five years. At this point in the questionnaire, those who did not provide therapy in the last five years did not continue to respond. Those respondents who have provided mental health services in the last five years continued to answer questions regarding the number of years in practice, theoretical orientation, client type, area of practice, feelings of professional isolation, place of residence in relation to place of work, and number of unintentional encounters with current or former clients (see Appendix A).

The changes made by this writer to the questionnaire include asking for a professional designation of registered psychiatric nurse (RPN) or registered nurse (RN) rather than having the respondent indicate profession as all respondents are nurses. The term

psychotherapy was changed to counselling after a review by the RPNAM. This term was chosen specifically because it could apply to the role of nursing more easily than that of psychotherapy. The term was not specifically defined to allow the respondent to determine what counselling meant to them. Unfortunately, this may have contributed to the low response rate if potential respondents did not identify with this term. Other minor structural changes were made to the questionnaire to facilitate the ease of data input.

Therapeutic Practices Survey

The Therapeutic Practices Survey consists of twenty items in which the respondent is requested to indicate a response on a six point likert scale from 0 to 5, including no opportunity, no clients, few clients, some clients, most clients, and all clients. The instructions on the questionnaire stated:

> Below are listed a number of behaviours which therapists may engage in as part of their clinical practice. Please indicate, by circling the appropriate number, the proportion of clients with whom you have engaged in the behaviour <u>when the opportunity was present</u>: ALL CLIENTS(5); MOST CLIENTS (4); SOME CLIENTS (3); FEW CLIENTS (2); OR NO CLIENTS (1). Use ALL CLIENTS (5) if your have engaged in the behaviour whenever the opportunity was present. Use NO OPPORTUNITY (0) if there was no opportunity to engage in the behaviour in any of the settings in which you have provided mental health services. Use NO CLIENTS (1) if at least one setting you have worked in offered the <u>opportunity</u> to engage

> in the behaviour but you chose not to.
>
> In responding to each item, please consider only treatment with adult clients (including family therapy and parent guidance). Unless otherwise indicated, items refer to behaviour engaged in with individuals who were in ongoing treatment at the time. (Borys, 1988, p. 198).

The incidence of reported sexual intimacy with a client was 0.2% for females and 0.9% for males, much lower than previous studies. This was attributed to two factors. First, the question was stated in such a way that the respondent may have felt that the question was asking if they were involved with a client now, rather than have they ever been involved with a client. Second, this could be due to the recent serious charges for such behaviour and, thus, respondents were less willing to indicate such transgressions. The question "engaging in sexual activity with a current client" was modified on the current questionnaire, at the suggestion of the previous authors, to make it clear that sexual activity with a current client included either presently or in the past. The item now states, "engaged in sexual activity with a client you were treating either now or in the past."

Other changes were made by replacing the word psychotherapy with counselling based on the review of the thesis proposal and questionnaires by the 13 board members and the executive director of the RPNAM. All but

two of these individuals are RPNs. The questionnaire was enlarged to cover two pages rather than one to facilitate readability. The review by the board functioned as a pilot study to determine face validity of the instrument. Based on this review the instruments were clear and the requests for information were felt to be interpreted by the RPNAM membership in the manner the author intended.

The present study does not use the same format as Borys (1988) who distributed half of the population a beliefs questionnaire and half a practices survey. This method was not used because access to the mailing list was not possible and therefore randomization of the two groups could not be ensured.

No evidence was found by Borys (1988) to suggest that responses to the belief or behaviour questionnaire would be distorted if the same individual provided information about both belief and behaviour. The use of the practices survey rather than the ethical beliefs questionnaire was felt to more clearly reflect the question the researcher wished to answer. In retrospect, the use of the beliefs questionnaire may have resulted in a higher return rate as it may have been less threatening for respondents to answer questions about what they believed rather than their own behaviour.

Data Collection

The Faculty of Education Research and Ethics Committee verified that the ethical standards required by the faculty were met. The RPNAM board and executive director supported the distribution of the survey to its members. As this was a completely anonymous survey written consent from respondents was not necessary for two reasons. First, all individuals who are currently registered with the RPNAM are over 18 years of age. Second, return of the questionnaire would indicate consent for the data to be used in the study. Respondents were informed that the results of the study will be published in their newsletter in approximately six months.

This study was supported by the RPNAM executive director. When the organization was approached with the idea for the study she requested that RPNAM members be the population chosen. It was indicated that the director felt the results would be valuable to the organization. Funding assistance for mailing, photocopy, and stationary costs were provided by the RPNAM. It was hoped that the support and sanction of the professional organization would generate a higher rate of return. An alternate possibility exists that some members of the population did not respond because they did not trust that the

responses would not be given to the RPNAM.

This study was survey research of an existing population. Each member of the RPNAM received along with their May newsletter, an introductory letter, demographic questionnaire and the therapeutic practices survey, along with a self addressed stamped return envelope (see Appendix A). The questionnaires were returned directly to the researcher, in order to guarantee anonymity and confidentiality of individual responses from the RPNAM. This was to assist in generating a higher rate of return.

The introductory letter briefly explained the purpose of the study, the anonymity, as well as the means of receiving results (see Appendix A). Subjects were asked to complete a questionnaire and to identify their characteristics of gender, age, marital status, years of experience, theoretical orientation, client type, work environment, social isolation, location of residence in relation to location of employment, and frequency of unintentional encounters with clients.

The surveys were printed on both sides of two sheets of brightly coloured pink paper to clearly differentiate the questionnaire from the newsletter. The questionnaires were left with the RPNAM to be distributed with the newsletter. Due to a delay in processing the newsletter the return date on the questionnaires was changed to June 24, 1996, one month following distribution. Unfortunately

a second delay resulted in the distribution not occurring until June 6, 1996. The return date still was June 24, 1996 with only two weeks for response. How this affected the return rate is unknown. On June 17, 1996 reminder cards (see Appendix B) were sent out by the RPNAM in order to increase the response rate.

Of the 1236 questionnaires sent, 259 were returned. Seven reminder cards were returned as undeliverable so it was assumed that the same number of questionnaires were undeliverable. Of those questionnaires returned 89 indicated that they had not provided counselling services in the past five years. Five responses were unusable because the questionnaire was not answered and only a note from the respondent was received. These 94 responses were not entered into the data analyses. Data analysis was performed on 165 completed questionnaires. This is a return rate of 14.4%. This is a low return rate but not uncharacteristic of this population. The RPNAM indicated that their membership had minimal experience with questionnaires and that the associations experience with return rates was that numbers were consistently low.

A strict cutoff date of July 2, 1996 was set. Ten questionnaires received after this date were not analyzed.

Data Analysis

For purposes of data analysis, Borys and Pope (1989) determined that because the responses on the therapeutic practices form were so heavily skewed toward never that factor analysis would not be a viable method of evaluation. As a result four composite indices were constructed by means of grouping conceptually similar meaningful factors. These indices were those Borys' (1989) identified by factor analysis: Incidental Involvements, Social Involvements, Financial Involvements, and Dual Professional Roles. Social and Financial Involvements were separated as no statistical basis for grouping them could be identified. The two items, "accepting a handshake" and "being sexually attracted to a client" were excluded because these items were used to indicate social desirability of responses the items themselves were not seen as potential boundary violations. The item concerning have sex with a client before termination was included in social involvements. The range of possible values were 0 to 15 for Incidental Involvements, 0 to 30 for Social Involvements, 0 to 30 for Dual Roles, and 0 to 25 for Financial Involvements. A total score for all four indices would range from 0 to 100.

The Incidental Involvements index included the

following items: accepting a gift worth under $10, accepting a client's invitation to a special occasion, and accepting a gift worth over $50. The Social Involvements index included the following items: becoming friends with a client after termination, engaging in sexual activity with a current client, engaging in sexual activity with a client after termination, disclosing details of one's current personal stresses to a client, inviting clients to an office/clinic open house, going out to eat with a client after a session, and inviting clients for a personal party or social event. The Financial Involvements index included the following items: accepting a service or product as payment for therapy, selling a product to a client, employing a client, borrowing less than $5 from a client, borrowed over $20 from a client, and buying goods or services from a client. The Dual Roles index includes the following items: providing therapy to a then-current employee, providing individual therapy to a relative, friend, or lover of an ongoing client, allowing a client to enrol in one's class for a grade, and providing therapy to a current student or supervisee.

Initial data analysis included indicating the frequency of male and female respondents. Frequencies were calculated for age of respondents as well as mean, median and mode age. The ages were then divided into

groups of less than 25, 25-34, 35-44, and 45-54 to facilitate comparison with existing population statistics. Frequencies were counted for marital status, professional designation, advanced specialization, clinical setting, social isolation, residence and encounters with clients. Total years providing counselling services will be calculated including the mean, median, and mode. Frequencies are also calculated for the client types. Data from the question regarding theoretical orientation were not analyzed. The question was answered incorrectly by over fifty percent of respondents indicating multiple theoretical orientations rather than only one. Because of the numerous combinations of responses data were deemed unusable.

Frequencies were calculated for each behaviour on the therapeutic practices survey as well as for the frequencies of behaviours within each of the four indices: incidental involvement, social involvement, financial involvement, and dual roles.

Data were analyzed by means of crosstabulations to compare the specific behaviours engaged in by RPNs with the frequency of the behaviour when the opportunity was present. Crosstabulated scores on each of the indices and each respondents total score with each of the demographic variables: gender, age, marital status, professional designation, advanced specialization, number of years of

counselling, client type, primary clinical setting, feelings of professional isolation, place of residence in relation to place of work, and number of unintentional encounters with current or former clients. In order to make the data more useful, respondent years of counselling were divided into categories of 1 to 5, 6 to 10, 11 to 15, 16 to 20, and 21 to 30 years. The scores on the therapeutic practices survey were also grouped. For the incidental index categories of scores were: 0 to 3, 4 to 6, 7 to 9, 10 to 12, 13 to 15. For the social index categories of scores included: 1 to 8, 9 to 16, 17 to 24, 25 to 32, 33 to 40. In the dual roles index the categories of scores were: 0 to 5, 6 to 10, 11 to 16, 17 to 20. In the financial index the score categories were 0 to 5, 6 to 10, 11 to 15, 16 to 20. These categories were created with the first category of each index representing scores that would have been indicated on each item by indicating zero or one. The second category included scores that would have been included by scoring two on each item. The third, fourth and fifth categories would have been those scoring three, four, and five respectively on each item of the index. The categories for each respondents total were created in the same manner. These score categories were 0 to 20, 21 to 30, 31 to 40, 41 to 55, 56 to 100.

To determine the statistical significance of these

results, One Way ANOVAs were performed for each of the four indices and the total score with each demographic variable. Alpha was set at .05. Post hoc Sheffé analyses were performed when appropriate.

CHAPTER IV

RESULTS

Characteristics of Respondents

Region of Residence

By analyzing postal codes on the valid returns it was found that 114 (69%) came from Winnipeg, 23 (14%) were rural, 6 (5%) were from out of province, 21 (13%) had no code, and one (0.6%) postal code was unreadable. No respondents were from the north of the 53rd parallel.

Gender

Of the respondents analyzed 128 (77.6%) were female and 37 (22.4%) were male. These data closely resemble those of the RPNAM membership.

Age

The age of respondents were divided into categories. Seven (4.3%) of the respondents were less than 25 years of age. Forty six (28.4%) were from 25 to 34 years. Sixty five (40.1%) were aged 35 to 44. Thirty nine (24.1%) were 45 to 54 years. Five (3.1%) respondents were 55 or

greater. Data were missing for 3 (1.8%) respondents. The mean age of respondents was 37.98 years. The mode was 34 years. The median was 37 years. The range was 21 to 63 years. The data indicated a normal distribution. (See Figure 1: Age of Respondents).

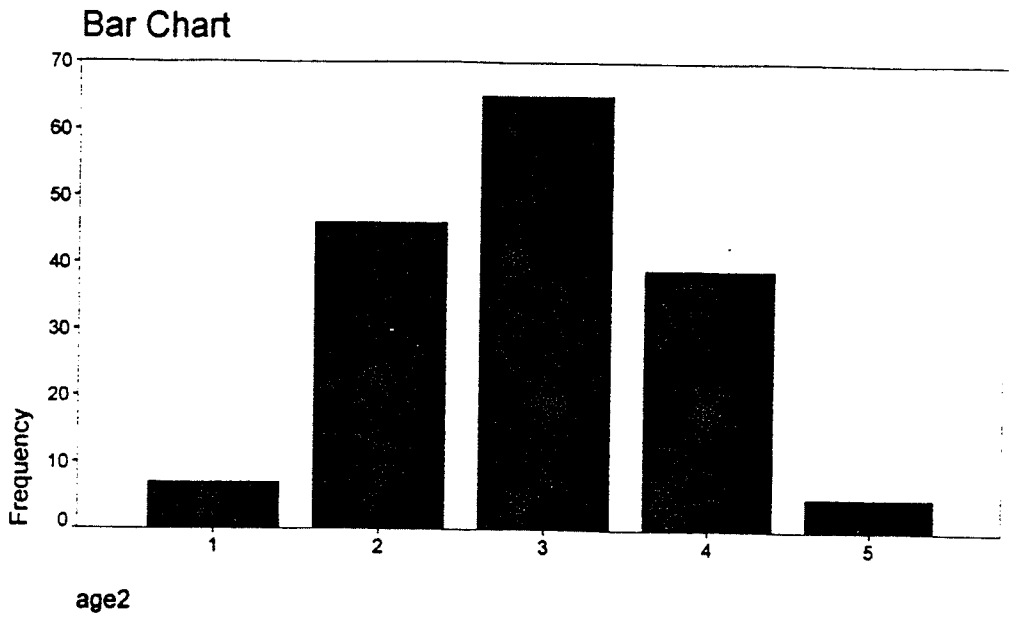
Marital Status

Marital status examined married, single, cohabitating and separated or divorced. Married respondents total 119 or 72.1%. Cohabitating was indicated by 4 or 6.7%. Nineteen (11.5%) indicated they were single. Sixteen (9.7%) indicated that they were divorced or separated.

Professional Designation

Professional designation was analyzed in terms of those with an RPN status or those with RPN plus further education. RPN only was indicated by 120 (72.1%) of respondents. Forty five (27.3%) indicated that they had an RPN status as well as further professional designations. some respondents indicated that they also held an RN or degrees/certificates in mental health.

Figure 1: Age of Respondents



Age Categories

1 = less than 25

2 = 25-34

3 = 35-44

4 = 45-54

5 = 55+

Advanced Specialization

Advanced specialization in mental health was indicated by 34 (20.6%) of respondents. No advanced specialization was indicated by 129 (78.2%). Data was missing for 2 (1.2%) respondents.

Years of Counselling

In order to make the data more meaningful, years of counselling was divided into categories. Fifty (30.3%) respondents had been counselling for one to five years. Thirty five (21.2%) had counselled for six to ten years. Thirty two (19.4%) had counselled for 11 to 15 years. Sixteen (9.7%) of respondents had been counselling for 16 to 20 years. Twenty one (12.7%) were counselling for 21 to 30 years. Data were missing for 11 (6.7%) respondents.

Client Type

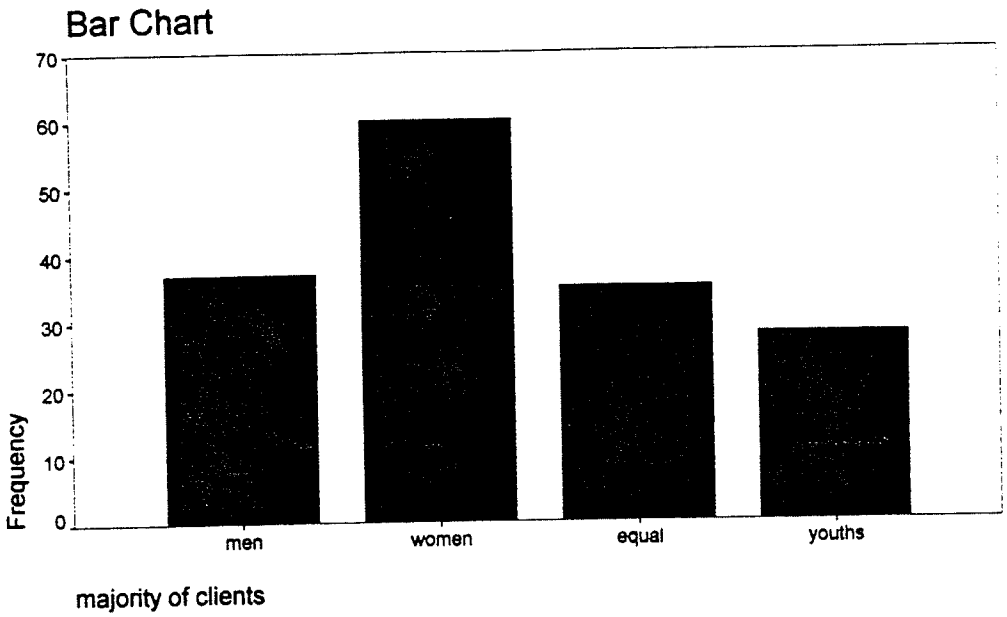
In order to make the data useful the proportions of client type for each respondent were divided into mostly men, mostly women, equal men and women, and mostly youths. Thirty seven (22.4%) respondents worked with a greater proportion of men. Sixty (36.4%) worked with mostly women. Thirty five (21.2%) worked with equal

proportions of men and women. Twenty eight (17%) respondents worked with a greater proportion of youth than adults. Data were missing for five (3%) of respondents.(See Figure 2: Proportion of Client Type). These figures appear to be appropriate as a greater number of women than men access mental health services because women may find it more acceptable to seek assistance from these resources (Canadian Mental Health Association, 1993). Another possibility is that men with mental health difficulties may more often be part of the penal system.

Primary Clinic Setting

The options for primary clinic setting included solo practice, group practice, outpatient clinic, inpatient clinic, community, and other. Eight (4.8%) of respondents indicated a solo practice was their primary setting. Seven (4.2%) respondents worked primarily in outpatient clinics. Seventy (42.4%) were employed in inpatient clinics. Fifty five (33.3%) worked in community settings. Twelve (7.3%) respondents indicated other. No respondents indicated group practice. Data were missing for 13 (7.4%) of respondents.

Figure 2: Proportion of Client Type



Professional Isolation

The options for indicating feelings of professional isolation included: "not at all"; "mildly"; "moderately"; and, "extremely isolated". Seventy five (45.5%) indicated they were not at all isolated. Forty nine (29.7%) indicated that they felt mildly isolated. Thirty (18.2%) indicated that they felt moderately isolated. Six (3.6%) felt extremely isolated. Data were missing for five (3%) respondents.

Of those individuals indicating they were extremely isolated 4 out of 6 indicated that they lived and worked within the same small community. One indicated they lived and worked in the same urban town and one lived and worked in two different communities.

Residence in Relation to Primary Clinic Setting

Respondents were asked to indicate whether they lived and worked in the same small town, within the same urban town, or in two different communities. Forty (25.5%) indicated they lived and worked in the same small town. Eighty (51%) indicated they lived and worked in the same urban town. Thirty seven (23.6%) lived and worked in two different communities. Data were missing for eight (4.8%).

Unintentional Encounters

An unintentional encounter included situations such as meeting a client at a social event where it was not planned or expected that a client would be seen: for example, attending a community fundraiser. Options for number of unintentional encounters with current or former clients outside the clinic setting included everyday, once per week, once per month, once per year, and never. Twenty three (13.9%) respondents indicated that they encountered current or former clients outside the clinic setting everyday. Fifty (30.3%) indicated once per week. Forty two (25.5%) indicated once per month. Thirty two (19.4%) indicated once per year. Never was indicated by thirteen (7.9%). Data were missing for four (2.4%) respondents.

Of those indicating that they had everyday unintentional encounters with clients 16 out of 23 were living and working in the same small town. Six indicated they lived and worked in the same urban town and one indicated that they lived and worked in two different communities.

In summary, the majority of respondents were from Winnipeg, female, educated as RPNs without further specialization, had been counselling from 1 to 5 years, and cared mostly for female clients in an inpatient

setting. These respondents also indicated that they did not feel professionally isolated, lived and worked in the same urban town and had unintentional encounters with clients once per week.

Therapeutic Practices

The frequencies and percentages for each response category to the items on the therapeutic practices survey are reported in Table 1. The majority of respondents indicated no opportunity or no clients to all items except "accepting a handshake offered by a client." The majority of respondents indicated all or most clients to this item.

The items on the therapeutic practices survey were divided into four indices: dual roles, financial, social, and incidental. The highest score for each index would indicate a total of "5" for all items in that index while a score of "0" would indicate a response of "0" to all items in that index. Four items were contained on the dual roles index resulting in a maximum score of 20. The financial index contained 5 items which would result in a maximum score of 25. The social index contained 8 items which would result in a maximum score of 40. The incidental index contained 3 items which would result in a maximum score of 15. Because 2 items were excluded for

social desirability the total number of items was 20, for a maximum total score of 100. As can be determined from Tables 2 and 3, the measures of central tendency and the ranges of scores were skewed toward the "0" response indicating that the incidence of these behaviours with clients are low.

Table 1: Frequency and Percentages of Behaviours

BEHAVIOURS	FREQUENCY OF CLIENTS FOR BEHAVIOURS					
	ALL	MOST	SOME	FEW	NO	NO OPPORTUNITY
Accepted gift under $10	0 (0)	1 (.6)	5 (3)	59 (35.8)	70 (42.4)	24 (17.6)
Accepted invitation special occasion	0 (0)	1 (.6)	2 (1.2)	22 (13.3)	82 (49.7)	57 (34.5)
Accepted product or service as payment	0 (0)	1 (.6)	1 (.6)	1 (.6)	98 (59.4)	64 (38.8)
Friends with client after termination	1 (.6)	2 (1.2)	2 (1.2)	17 (10.3)	109 (66.1)	34 (20.6)
Sold product to client	0 (0)	0 (0)	0 (0)	3 (1.8)	103 (62.4)	58 (35.2)
Accepted gift worth $50	0 (0)	0 (0)	0 (0)	2 (1.2)	98 (59.4)	64 (38.8)
Provided therapy to current employee	0 (0)	2 (1.2)	5 (3)	24 (14.5)	69 (41.8)	64 (38.8)
Sexual activity with client after termination	0 (0)	0 (0)	0 (0)	2 (1.2)	94 (57)	65 (39.4)
Borrowed less than $5 from client	0 (0)	0 (0)	0 (0)	2 (1.2)	107 (64.8)	65 (39.4)

Table 1 contd: Frequency and Percentages of Behaviours

BEHAVIOURS	FREQUENCY OF CLIENTS FOR BEHAVIOURS					
	ALL	MOST	SOME	FEW	NO	NO OPPORTUNITY
Accepted handshake	71 (43)	37 (22.4)	32 (19.4)	16 (9.7)	2 (1.2)	1 (.6)
Sexually attracted to client	2 (1.2)	2 (1.2)	2 (1.2)	32 (19.4)	89 (53.9)	22 (13.3)
Details of personal stresses	0 (0)	1 (.6)	7 (4.2)	6 (3.6)	75 (45.5)	58 (35.2)
Borrowed over $20 from client	0 (0)	0 (0)	0 (0)	1 (.6)	113 (68.5)	50 (30.3)
Invited client to clinic open house	9 (5.5)	8 (4.8)	7 (4.2)	6 (3.6)	75 (45.5)	58 (35.2)
Employed client	1 (.6)	1 (.6)	1 (.6)	9 (5.5)	85 (53.3)	65 (39.4)
Out to eat with client	0 (0)	1 (.6)	7 (4.2)	22 (13.3)	85 (51.5)	48 (29.1)
Bought goods or services from client	0 (0)	1 (.6)	1 (.6)	30 (18.2)	88 (53.3)	45 (27.3)
Sexual activity with current client	0 (0)	0 (0)	0 (0)	0 (0)	108 (65.5)	56 (33.9)
Invited clients to personal party	0 (0)	1 (.6)	6 (3.6)	0 (0)	106 (64.2)	51 (30.9)

Table 1 contd: Frequency and Percentages of Behaviours

BEHAVIOURS	FREQUENCY OF CLIENTS FOR BEHAVIOURS					
	ALL	MOST	SOME	FEW	NO	NO OPPORTUNITY
Provided therapy to friend, relative or lover of client	0 (0)	4 (2.4)	14 (8.5)	19 (11.5)	79 (47.9)	48 (29.1)
Therapy to student or supervisee	0 (0)	2 (1.2)	1 (.6)	17 (10.3)	85 (51.5)	59 (35.8)
Allowed client to enrol in class for grade	0 (0)	0 (0)	0 (0)	0 (0)	65 (34.4)	99 (60)

Note: Numbers in parenthesis are percentages of total respondents. Percentages not totalling 100 are due to missing data.

Table 2

Means of Index and Total Scores

Index	Mean	Median	Mode	SD
Dual Role	3.11	3.0	4.0	2.265
Financial	3.62	5.0	5.0	2.205
Social	6.88	8.0	8.0	4.034
Incidental	2.71	3.0	3.0	1.604
Total Scores	16.21	19.0	20.0	8.923
			22.0	

Table 3

Range of Index Scores

Index	Range of Scores	Possible Maximum Scores
Dual Role	0-12	20
Financial	0-11	25
Social	0-27	40
Incidental	0-6	15
Total Scores	0-54	100

Relationships Among Variables

The variables of sex, age, marital status, professional designation, advanced specialization in mental health, years of counselling, client type, primary clinic setting, feelings of isolation, residence in relation to employment, and number of unintentional encounters with current or former clients were crosstabulated with scores on the indices of dual roles, financial, social, and incidental scores. The only variable where an obvious pattern was visible was in that of unintentional encounters. As the number of unintentional encounters increased, so did the scores on each of the indices and the total score.

One other noted piece of information was that there was one outlying high score in several categories. When the raw data was reviewed it was apparent that these responses were obtained by one male respondent. This individual was married, an RPN with five years of experience, feeling mildly isolated, living and working in the same small town and encountering clients unintentionally everyday. Because of the nature of this individual's responses it appeared to the researcher that this individual may have had sexual contact with clients but was reluctant to report this. An alternate explanation may have been that the individual may have been unaware of less serious potential boundary violating behaviours, but did appear to be aware of more obvious violations. This respondent indicated most clients to ten items, all clients to four items, some clients to one item, and no opportunity to seven items. This individual scored high on the incidental and financial indices but others scored similarly. The scores on the dual roles, social index, and total scores were double that of other respondents. Because the respondent did not indicate the maximum for each question, it was assumed that this was not fictitious and the data was included in the analysis. For a review of crosstabulated data the reader is referred to Appendix C.

Significance of the Relationship Between Respondent's Characteristics and Therapeutic Practices Behaviours

One way ANOVAs were performed on the variables of sex, age, marital status, professional designation, advanced specialization in mental health, number of years of counselling, client type, primary clinic setting, feelings of isolation, residence in relation to primary clinic setting, and number of unintentional encounters with the scores of the indices and the total score of the therapeutic practices survey. The ANOVAs were conducted to test the hypotheses that there were no differences between groups in each of the variables on each of the indices and the total score.

The F ratio in the ANOVA for age and incidental scores indicates a significant difference between the mean scores on the financial index for the four age categories ($F(3, 152)=3.1248$, $p=.0277$). This indicates that no difference between the means of the groups is present in 2.7% of situations when the F ratio is 3.12 or greater, therefore the null hypothesis that there is no difference between the groups is rejected. Therefore, it can be accepted that a significant difference exists between the mean scores on the financial index for each of the four age categories. See ANOVA Table 4 below. The post hoc Sheffé analysis indicates no significant

difference between the groups at the .05 level. Because the Sheffé is a conservative measure of significance, the difference found by ANOVA may not have been detected. A larger sample size would have provided more power to the analysis. Perhaps with a larger sample size significance would have been demonstrated at the .05 level.

Table 4

Analysis of Variance for Age Groups and Incidental Scores

Source	df	SS	MS	F	p
Between Groups	3	2.0138	.6713	3.1248	.0277
Within Groups	152	32.6529	.2148		
Total	155	34.6667			

The F ratio of the ANOVA for the incidental index scores for the groups of number of years of counselling was found to be statistically significant ($F(4, 149)=3.0139$, $p=.0200$). See ANOVA Table 5 below. This indicates that in 98% of cases when the F ratio is 3.01 or greater a significant relationship exists between the groups. Post hoc Sheffé analysis revealed that statistically significant differences existed between the means of the group who had been counselling for 1 to 5 years and the group who had been counselling 11 to 15 years. This demonstrated that those individuals

counselling 11 to 15 years had higher scores on the incidental index than those counselling 1 to 5 years. A high score indicates that the therapist has accepted more gifts and invitations to special occasions. This may be the result of professionals who have had a greater number of clients or longer term relationships with clients resulting in an invitation to a special occasion such as a wedding or receiving a gift. No other variables had statistically significant differences between groups.

Table 5

Analysis of Variance for Groups of Numbers of Years of Counselling and Incidental Index Scores

Source	df	SS	MS	F	p
Between Groups	4	2.5008	.6252	3.0139	.0200
Within Groups	149	30.9083	.2074		
Total	153	33.4091			

The F ratio for the means of financial index scores for primary clinic setting groups indicates a significant difference among these groups ($F(4, 147)=3.3148$, $p=.0124$). See ANOVA Table 6 below. The post hoc Sheffé indicates no significant difference at the .05 level between primary clinic setting groups on means of financial index scores. Because of the conservative

nature of the Sheffé test and the small sample size one is unable to determine where groups the significant differences lie. By examining the crosstabs it would appear that the differences are between those in outpatient clinics and those in solo practices. This would mean that individuals in solo practices score lower on the financial index than those in outpatient clinics. This may be the result of the fact that in solo practice the individual is paid directly by the client and in an outpatient clinic the individual is paid by an institution. Therefore, individuals in solo practice may be more aware of the dangers of alternate financial involvements with clients.

Table 6

Analysis of Variance for Groups of Primary Clinic Setting and Financial Index Scores

Source	df	SS	MS	F	p
Between Groups	4	1.4784	.3696	3.3148	.0124
Within Groups	147	16.3900	.1115		
Total	151	17.8684			

The F ratio for the dual roles index scores for the three groups of residence while in primary clinic setting indicates a significant difference among the mean scores

($F(2, 154)=4.5399$, $p=.0121$). See ANOVA Table 7 below. This means that in 88% of cases for an F ratio of 4.54 or greater a significant difference exists among the means of the dual roles index scores for the three groups of residence in relation to primary clinic setting. This rejects the null hypothesis that no difference exists.

Post hoc Sheffé analysis indicates that the significant differences occurred between those living and working in the same small town and those living and working in the same urban town. A significant difference also exists between those living and working in the same small town and those living and working in two different communities. No significant difference was found between those living and working in the same urban town and those living and working in two different communities. This indicates that it is significantly more likely for an individual living and working in the same small town to have dual roles with clients than those living and working in the same urban community or those living and working in two different communities. This would appear to be a logical finding as most members of small towns already know other community members.

Table 7

Analysis of Variance for Groups Residence and Dual Roles Scores

Source	df	SS	MS	F	p
Between Groups	2	1.1242	.5621	4.5399	.0121
Within Groups	154	19.0669	.1238		
Total	156	20.1911			

For the F ratio of the financial index scores and groups of the number of unintentional encounters with current or former clients, a significant difference was found among the mean scores ($F(4, 155)=3.2310$, $p=.0001$). See ANOVA Table 8 below. This means that in 99.99% of cases when the F ratio is 3.23 or greater a significant difference exists, thus, rejecting the null hypothesis. Post hoc Sheffé analysis revealed that significant differences existed at the .05 level between the group indicating everyday and the two groups indicating once per year and never. Therefore, the group indicating everyday scored significantly higher on the financial index than individuals indicating once per year and never. Once again demonstrating that as the number of unintentional encounters increases so do the opportunity for potential boundary violating situations.

Table 8

Analysis of Variance for Groups of Numbers of Unintentional Encounters and Financial Index Scores

Source	df	SS	MS	F	p
Between Groups	4	3.0693	.7673	6.6424	.0001
Within Groups	155	17.9057	.1155		
Total	159	20.9750			

For the F ratio of the incidental index scores and the groups of the number of unintentional encounters with current or former clients, a significant difference was found in the mean incidental index scores ($F(4,155)=6.9169$, $p=.0000$). See ANOVA Table 9 below. This means that with an F ratio of 6.92 or greater the null hypothesis that no difference exists is rejected. Post hoc Sheffé analysis revealed differences at the .05 level the group indicating everyday and the three groups indicating never, once per year, and once per month. Statistically significant differences at the .05 level also existed between the group indicating once per week and the two groups indicating once per month and once per year. The group indicating everyday scored significantly higher on the incidental index than those indicating never, once per year, and once per month. The group indicating once per week also scored significantly higher

on the incidental index than those indicating once per month and once per year. No statistical difference existed between those indicating everyday and once per week. This would indicate that individuals who encounter clients everyday, or once per week are more likely to accept a gift or an invitation to a special occasion than individuals who encounter clients less frequently.

Table 9

Analysis of Variance for Group of Numbers of Unintentional Encounters and Incidental Index Scores

Source	df	SS	MS	F	p
Between Groups	4	5.3164	1.3291	6.9169	.0000
Within Groups	155	29.7836	.1922		
Total	159	35.1000			

For the F ratio of the ANOVA for the dual roles index scores and the groups of numbers of unintentional encounters with current or former clients, a significant difference was found among the means ($F(4,155)=6.6424$, $p=.0001$). See ANOVA Table 10 below. This means that in 99.99% of cases with an F ratio of 6.64 or greater the null hypothesis that no difference exists is rejected. Post hoc Sheffé analysis revealed statistically significant differences at the .05 level for the group

indicating everyday and the three groups indicating once per month, once per year, and never. This means that the group indicating everyday scored significantly higher on the dual roles index than those indicating once per month, once per year and never. Therefore the greater the number of unintentional encounters the higher the dual roles index score.

Table 10

Analysis of Variance for Group of Numbers of Unintentional Encounters and Dual Roles Index Scores

Source	df	SS	MS	F	p
Between Groups	4	3.0693	.7673	6.6424	.0001
Within Groups	155	17.9057	.1155		
Total	159	20.9750			

For the F ratio of the ANOVA for the social index scores and the unintentional encounters with current or former clients, a significant difference was found among the means ($F(4, 155)=5.0556$, $p=.0008$). See ANOVA Table 11 below. This means that for an F ratio of 5.06 or greater 99.92% of the time the null hypothesis that no difference exists is rejected. Post hoc Sheffé analysis revealed significant differences at the .05 level between the group indicating everyday and the two groups indicating

once per year and never. This indicates that the group selecting everyday scored significantly higher on the social index than those indicating once per year and never. Therefore, as the number of unintentional encounters increases so does the incidence of potential boundary violations on the social index.

Table 11

Analysis of Variance for Group of Numbers of Unintentional Encounters and Social Index Scores

Source	df	SS	MS	F	p
Between Groups	4	4.8707	1.2177	5.0556	.0008
Within Groups	155	35.8889	.2409		
Total	159	40.7597			

The F ratio for the ANOVA for the total score means for the groups of numbers of unintentional encounters with current or former clients a significant difference was found among the means ($F(4, 155)=6.7337$, $p=.0001$). See ANOVA Table 12 below. Post hoc Sheffé analysis revealed that significant differences existed at the .05 level between the group indicating everyday and the three groups indicating once per month, once per year, and never. This means that as the number of unintentional encounters increases so do the total scores on the

therapeutic practices survey. It is apparent that no significant difference occurs whether encounters occur daily or weekly but differences are apparent with encounters occurring less frequently.

Table 12

Analysis of Variance for Groups of Numbers of Unintentional Encounters and Total Scores

Source	df	SS	MS	F	p
Between Groups	4	1886.1797	471.5449	6.7337	.0001
Within Groups	149	10434.1579	70.0279		
Total	153	12320.3377			

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

Characteristics of the Sample

The entire population of the Registered Psychiatric Nurses of Manitoba was sent a copy of the demographic questionnaire and the therapeutic practices survey. Of the 1236 questionnaires sent 259 were returned. Of those returned 165 were used for data analysis. This is a return rate of 14.4%. In order to determine the representativeness of the sample to the population, characteristics of the sample were compared to those known about the population.

The region of residence for the respondents in this study included 69% Winnipeg, 14% rural, 5% out of province, and 0% northern. When compared to the statistics for the RPN population of 31.9% Winnipeg, 67% rural, and 1.1% northern, it is obvious that the respondents are biased in terms of urban respondents. Because it appears that the scores for those living and working in the same small town are higher than those in urban areas this may have affected the results. If scores for those living and working in the same small town

(which would be indicated as rural) are higher on some indices then, it is likely that a large number of those who did not respond may have had higher scores than those who did respond of which the majority were urban. This bias in terms of residence may also indicate a bias in terms of those more likely to score lower on the indices.

The respondents in this study included 77.6% females and 22.4% males. This is similar to the RPNAM statistics of 72% female and 28% male. Therefore no bias is apparent in terms of representation by each gender.

In terms of age, those less than 25 comprised 4.3% of the sample, 25 to 34 were 28.4%, 35 to 44 were 40.1%, 45 to 54 were 24.1% and 55 or greater were 3.1%. This compares to the 1994 statistics of the RPN with those less than 25 being 2.6%, 25 to 34 were 24.3%, 35 to 44 were 36.4%, 45 to 54 were 29.1%, and 55 or greater were 7.6%. The small differences in the less than 25 group and the 55 or greater group might be accounted for by new graduates and those retiring. The age distribution of the sample was a normal curve.

The largest group of client type indicated was mostly women. This would compare to the fact that the majority of clients seen in mental health treatment are female (Canadian Mental Health Association, 1993).

Summary of Findings

The frequency of responses to all behaviours on the therapeutic practices survey were skewed toward no opportunity or no clients. No respondents indicated that they were having sexual intercourse with a current client. Two respondents indicated that they had a sexual relationship with a few clients after termination. One of these respondents was female and the other male. This indicates that 1.21% of the responses analyzed were involved in a sexual relationship with a previous client at some time. This compares to Borys and Pope's (1989) rate of 1.1% for sexual involvement with clients. The gender distribution in Borys and Pope (1989) was .2% women and .9% men. In this study the gender distribution of those indicating a sexual relationship with a client after termination was 50%. This may have been related to the unequal distribution of men and women in the population. As indicated by Borys' and Pope (1989) this rate is much lower than that found in other studies. One reason for a lower incidence of sexual involvement with clients may have been the increased awareness of these issues which may have resulted in a decreased occurrence or inaccurate reporting by respondents afraid of sanctions. This awareness may also have discouraged nonrespondents from reporting. Another reason may have

been that the environments in which nurses are employed do not readily lend themselves to secret liaisons. The public nature of the institution or ward setting does not allow for the privacy of that in a psychologist's or psychiatrist's office.

Significant differences were found between scores of those living and working in the same small town and the other two groups, living and working in the same urban town, and living and working in two different communities. Because of these differences it may be assumed that it is more difficult to avoid potential boundary violating situations in a small town. This may also explain the findings that the greater the number of unintentional encounters, the higher the scores on the four indices and total score of the therapeutic practices survey. It would follow that one would have more unintentional encounters with current or former clients living and working in the same small town. With this information it is perhaps useful that associations such as the RPNAM or agencies hiring individuals to provide counselling look closely at the difficulties inherent in living and working in the same small community. Perhaps this arrangement is not in the best interest of the counsellor or the client. At a minimum these counsellors should have the opportunity to have further education and support to assist them in identifying the specific

boundary concerns in their situation. This may occur through debriefing or psychological supervision, or perhaps through professional support networks.

Based on the responses to the theoretical orientation, it appears that nurses do not identify themselves as adhering to one particular orientation. Rather than indicating one specific orientation, nurses indicated several. The combinations of orientations selected were so diverse that analysis of the data was impossible. In psychiatry and psychology the practitioner tends to identify with a single theoretical background, although several may be used.

This difference may result from the fact that as a profession attempting to establish itself, nursing has incorporated various theoretical views from the multiple disciplines with whom close working relationships exist. Another reason may have been poor formatting of the question, although, this did not appear to be a problem in the pilot review.

Selection is a problem in this study because the sample is self selecting. The characteristics of those who choose to respond may be different than those who do not chose to do so. The desire to achieve anonymity to increase the reliability of self reporting is more desirable than ensuring a random sample. One way to eliminate the concern of the differences between the

population and the self selecting sample is to compare the demographic characteristics of the sample with those of the population. As indicated above the age and gender of the sample are representative of the population but the region of residence in biased in terms of an urban setting. Unfortunately, it is impossible to determine what the responses of those who did not respond would have been. Because of the potential for higher scores of those living and working in the same small community, the urban bias may have biased the sample in terms of those with lower scores.

The greatest threat to the validity of the study is the return rate of the questionnaires. In order to maximize the return rate postage paid envelopes were provided, the RPNAM approved the study, and reminder cards were sent. The short return time may have either increased or decreased the return rate. It was impossible to determine, although, ten questionnaires were received after the cutoff date. If the response time had been longer, or perhaps if the study had been conducted in the winter months, the response rate may have been greater.

The low return rate brings into question the validity of the results on the variables where no difference was demonstrated. As the results of the sample were skewed toward never the statistical power necessary may not have existed with this small sample size. Perhaps

with a larger return rate the differences among the variables would have been significant.

Because this population was a very specific group within the larger nursing profession, comparisons to other specialities of nurses cannot be made. Minimal comparisons may be made cautiously to other groups of RPNs. By collecting demographic statistics other groups may be examined for their similarities to this population to identify whether or not even guarded comparisons could be attempted.

Conclusions

Based on the results of this study the following conclusions seem warranted:

The primary conclusion was that registered psychiatric nurses in Manitoba who live and work in the same small town or who have a greater number of unintentional encounters with current or former clients, scored higher on the therapeutic practices survey indicating a higher number of possible boundary violating behaviours. Several possible explanations exist for this conclusion. First is that those who live and work in the same small town are unable to avoid a certain amount of contact with previous or current clients because daily living in a small town may result in one individual

interacting in a variety of roles with other community members. A second explanation is that as the number of unintentional encounters increases so does the familiarity between the individuals thus increasing the potential for boundary violations.

A second conclusion in this study is that those nurses who are no longer currently providing counselling services respond at a higher rate than those who are currently in practice. Several explanations may exist for this. The first is that those who were no longer counselling, only completed six questions while those who were counselling completed both questionnaires. As well, those who were no longer counselling were not required to indicate their behaviours so they would not feel threatened by the questions. A final explanation for this, may be that many of those no longer working directly with clients may be in professional positions where an appreciation for research has been cultivated.

The response rate for this population of nurses is low. Perhaps the time frame for return of the questionnaires provided a difficulty although, the RPNAM reported similar difficulties in the past. One factor in this low response rate may be that this population has seldom been used for research and therefore are unaccustomed to the process. Another reason may be that many nurses did not relate to their work as involving

counselling. The most likely reason for the low response rate is that offense was taken to the personal nature of the questions.

In future this method of data collection with nurses does not appear to be effective for sensitive subjects. Perhaps telephone interviews, or face to face interviews with a smaller number of individuals would yield useful data.

The validity of the responses indicating that no statistical differences existed is highly questionable. No variables should be eliminated based on this study. Those variables that did show statistical significance could be considered valid based on significance although, these results are based on a small sample of the rural population. The confidence of the researcher in the results obtained regarding unintentional encounters is high because it has been documented in previous research and because it is statistically significant across all 4 indices and the total score.

A third conclusion of this study is that it is not useful to ask nurses to identify with a specific theoretical orientation. Based on the results of this study nurses appear to identify with a variety of theoretical orientations, rather than defining their practice by one theoretical orientation.

Recommendations

Because this study is a preliminary work in the nursing profession, the possibilities for future study are many. This study could be repeated with other specialties of nurses, or with registered nurses working in mental health areas. If the study is repeated it may be more useful to ask about beliefs rather than behaviours, due to the less threatening nature of the questions. An alternate view could be taken and clients of nurses in mental health could be studied to determine how frequently potential boundary violating behaviours occur as reported by clients. Clients perceptions of these behaviours could also be studied. Qualitative studies could be undertaken to identify the presence of other variables specific to nursing that are not identified in the existing literature. Difficulties of professionals or clients in reporting boundary violations to authorities could be examined.

The need to continue to educate mental health professionals about boundaries is important. As indicated in the definition of boundaries in this paper, it is impossible to set concrete rules about boundaries as they are a function of the individuals and the environment in which the events occur. Nursing does not provide for formal psychological supervision such as that carried out

in specialties such as psychology or psychiatry where a safe non-threatening environment is provided for professionals to discuss their feelings and errors in terms of boundary violations. Through education and discussions in a safe environment professionals can explore boundaries and develop their own personal guidelines that work for them. Supervision in nursing was a concept that was explored by Platt-Koch (1986) as an effective learning opportunity to refine assessment, diagnosis, and treatment skills. Through this process professional strengths and weaknesses, as well as learning needs can be identified. Support networks for nurses in isolated or rural situations could provide a forum for discussion.

By addressing issues related to boundaries and providing open discussions it is possible that a number of violations due to lack of knowledge may be avoided and possible means of repairing damage from minor infractions can be developed. Although the numbers of infractions are small, the damage caused to the client and the professional can be long lasting.

References

Barnsteiner, J.H. and Gillis-Donovan, J. (1990). Being related and separate: A standard for therapeutic relationships. MCN, 15(7), 223-228.

Borys, D.S. (1988). Dual relationships between therapist and client: A national study of psychologists, psychiatrists, and social workers. Copyrighted Ph.D Dissertation, UCLA, Los Angeles, California.

Borys, D.S., and Pope, K.S. (1989). Dual relationships between therapist and client: A national study of psychologists, psychiatrists, and social workers. Professional Psychology: Research and Practice, 20(5), 283-293.

Brodsky, A.M. (1986). The distressed psychologist: Sexual intimacies and exploitation, in Kilburg, R., Nathan, P. and Thoreson, R. (eds.), Professionals in Distress: Issues, Syndromes, and Solutions in Psychology. Washington, DC: American Psychological Association.

Brown, L. (1988). Beyond thou shalt not: Thinking about ethics in the lesbian therapy community. Women and Therapy, 8(1-2), 13-25.

Brown, L. (1994). Boundaries in feminist therapy: A conceptual formulation. Women and Therapy, 15(1), 29-38.

Canadian Association of Social Workers (1994). Code of Ethics. Ontario: Author.

Canadian Mental Health Association (1993). Women's Voices Shall Be Heard: Report on the Sexual Abuse of Women by Mental Health Service Providers. Winnipeg, MB: Author.

Canadian Nurses Association. (1991). The CNA Code of Ethics. Ontario: Author.

College of Nurses of Ontario (1995). One Is One Too Many. Ontario: Author.

College of Physicians and Surgeons of Manitoba. Guideline: Sexuality and the Doctor/Patient Relationship. Winnipeg, MB: Author.

Disch, E. (1989). When intimacy goes awry. Women of Power, 139(spring), 54-57.

Epstein, R.S. (1994). Keeping Boundaries: Maintaining Safety and Integrity in the Psychotherapeutic Process. Washington, DC: American Psychiatric Press.

Epstein, R.S., and Simon, R.I. (1990). The Exploitation Index: An early warning indicator of boundary violations in psychotherapy. Bulletin of the Menninger Clinic, 54, 450-465.

Epstein, R.S., Simon, R.I., and Kay, G.G. (1992). Assessing boundary violations in psychotherapy: Survey results with the Exploitation Index. Bulletin of the Menninger Clinic, 56, 150-166.

Gafner, G. and Trudeau, V. (1988). Boundaries: Ethical issues in client-professional relationships. EAP

Digest, September/October, 70-75, 90.

Gallop, R. (1993). Sexual contact between nurses and patients. The Canadian Nurse, 89(2), 28-31.

Gartrell, N., Herman, J., Olarte, S., Feldstein, M., and Localio, R. (1986). Psychiatrist-patient sexual contact: Results of a national survey, I: Prevalence. American Journal of Psychiatry, 143(9), 1126-1131.

Gartrell, N., Herman, J., Olarte, S., Localio, R., and Feldstein, M. (1988). Psychiatric residents' sexual contact with educators and patients: Results of a national survey. American Journal of Psychiatry, 145(6), 690-4.

Gelles, R. (1978). Methods for studying sensitive family topics. American Journal of Orthopsychiatry, 48, 408-424.

Guthiel, T.G. & Gabbard, G.O. (1993). Approaches to forensic assessment of false claims of sexual misconduct by therapists. Bulletin of the American Academy of Psychiatry and the Law, 150(), 188-196.

Heywood-Jones, I. (1990). Dangerous liaisons. Nursing Times, 86(3), 57-58.

Hicks, C. (1981). The whistle blowers...reasons mental nurses are forced to remain silent about patient abuse. Nursing Times, 77( ), 1921.

Kagle, J.D., and Giebelhausen, P.N. (1994). Dual relationships and professional boundaries. Social Work,

39(2), 213-220.

Kardner, S.H., Fuller, M., and Mensh, I.N. (1973). A survey of physicians' attitudes and practices regarding erotic and nonerotic contact with patients. American Journal of Psychiatry, 130(10), 1077-81.

Linklater, D., and MacDougall, S. (1993). Boundary issues: What do they mean for physicians. Canadian Family Physician, 39, 2569-2573.

Lourie, I.S. (1977). The phenomenon of the abused adolescent: A clinical study. Victimology, 2, 268-276.

Lymberis, M.T. (1994). Boundary violations in psychotherapy: Sexual and nonsexual in Sugarman, A. (ed.) Victims of Abuse: The Emotional Impact of Child and Adult Trauma. Madison, Connneticut: International Universities Press Inc. p. 165-186.

Manitoba Association of Registered Nurses. (1994). Definitions of "Professional Misconduct" "Conduct Unbecoming a Member" and "Incapability or Unfitness to Practice Nursing." Winnipeg, MB: Author.

Manitoba Nursing Professions Advisory Council (1995). "Nursing Resources in Manitoba." Winnipeg, MB: Author.

Markowitz, L.M. (1992). When therapy does harm: Crossing the line. Networker, November/December, 25-31.

Menninger, W.W. (1991). Identifying, evaluating, and responding to boundary violations: A risk management

program. Psychiatric Annals, 21(11), 675-680.

Morse, J.M. (1989). Reciprocity for care: Gift giving in the patient-nurse relationship. The Canadian Journal of Nursing Research, 21(1), 33-46.

Munsat, E.M., and Riordan, J.J. (1990). Under wraps: Prevalence of staff-patient sexual interactions on inpatient units. Journal of Psychosocial Nursing, 28(9), 23-26.

Nursing '74 (1974). Sexual involvements. Nursing '74, September, 43-44.

Pages, K.P., Maxim, P.E., and Wasch, H. (1994). An inpatient team's response to alleged sexual misconduct by an outpatient psychotherapist. Hospital and Community Psychiatry, 45(12), 1231-1232.

Parsons, J.P. and Wince, J.P. (1995). A survey of client-therapist sexual involvement in Rhode Island as reported by subsequent treating therapists. Professional Psychology: Research and Practice, 26(2), 171-175.

Pennington, S., Gafner, G., Schilit, R., and Bechtel, B. (1993). Addressing ethical boundaries among nurses. Nursing Management, 24(6), 36-39.

Perry, J.A. (1976). Physicians' erotic and nonerotic physical involvement with patients. American Journal of Psychiatry, 133(7), 838-840.

Peterson, M.R. (1992). At Personal Risk: Boundary Violations in Professional-Client Relationships. New

York: W.W. Norton and Co.

Pilette, P.C., Berck, C.B., and Achber, L.C. (1995). Therapeutic management of helping boundaries. Journal of Psychosocial Nursing, 33(1), 40-7.

Platt-Koch, L.M. (1986). Clinical supervision for psychiatric nurses. Journal of Psychosocial Nursing, 26(1), 7-15.

Pope, K. (1988). How clients are harmed by sexual contact with mental health professionals: The syndrome and its prevalence. Journal of Counseling and Development, 67, 222-226.

Regan Report on Nursing Law (1991). Sexual relationship with patient: License revocation. Regan Report on Nursing Law, 2(2), 4.

Regehr, C., and Glancy, G. (1995). Sexual exploitation of patients: Issues for colleagues. American Journal of the Orthopsychiatric Association, 65(2), 194-202.

Registered Psychiatric Nurses of Manitoba. (1992). Sexual Exploitation and Abuse by Mental Health Service Providers Position Statement. Winnipeg, MB: Author.

Rinella, V.J. and Gerstein, A.I. (1994). The development of dual relationships: Power and professional responsibility. International Journal of Law and Psychiatry, 17(3), 225-237.

Ryder, R. and Hepworth, J. (1990). AAMFT ethical

code: "Dual relationships." Journal of Marital and Family Therapy, 16(2), 12-132.

Schoener, G.R., Milgrom, J.H., Gonsiorek, J.C., Luepker, E.T., and Conroe, R.M. (1989). Psychotherapist's Sexual Involvement With Clients: Intervention and Prevention. Minneapolis, MN: Walk-in Counseling Centre.

Schulz, W. (Ed.) (1989). Guidelines for Ethical Behaviour of the Canadian Guidance and Counselling Association. Canadian Guidance and Counselling Association: Ottawa.

Sigsby, L.M. (1991). Crisis and ethical dilemmas: Who will care for the rural nurse? Heart and Lung, 20(5), 523-5.

Simon, R. (1989). Sexual exploitation of patients: How it begins before it happens. Psychiatric Annals, 19(2), 104-112.

Smith-Ramsdell, P. and Ramsdell, E.R. (1993). Dual relationships: Client perceptions of the effect of client-counsellor relationship on the therapeutic process. Clinical Social Work Journal, 21(2), 195-212.

Soreff,S. & Hymoff, I. (1976). The practice of dynamic psychotherapy in a circumscribed community. American Journal of Psychotherapy, 30(4), 658-665.

Strasburger, L.H., Jorgenson, L., and Sutherland, P. (1992). The prevention of psychotherapist sexual misconduct: Avoiding the slippery slope. American Journal

of Psychotherapy, 46(4), 544-555.

Trudeau, V.M., and Gafner, G. (1988). Boundaries. ETHICON Point of View, 25(2), 14-15.

Vasquez, M.J.T. (1991). Sexual intimacies with clients after termination: Should a prohibition be explicit? Ethics and Behaviour, 1, 45-61.

White, G.E., Coverdale, J.A., and Thomson, A.N. (1994). Can one be a good doctor and have a sexual relationship with one's patient? Family Practice, 11( ), 389-393.

Zelen, S.L. (1985). Sexualization of therapeutic relationships: The dual vulnerability of patient and therapist. Psychotherapy, 22(2),

Appendix A

Introductory Letter, Demographic Questionnaire and Therapeutic Practices Survey

These questionnaires were adapted from the copyrighted dissertation of Debra Borys (1988) "Dual Relationships Between Therapist and Client: A National Study of Psychologists, Psychiatrists, and Social Workers." completed at UCLA.

Bernadine Desender
956 Alfred Ave.
Winnipeg, MB

R2X OV2

Dear RPNAM member,

My name is Bernadine Desender. I am a student at the University of Manitoba and have been an active practising Registered Nurse for ten years. Currently I am conducting a research thesis to complete my master of education degree in educational psychology. This study has been reviewed and supported by the board of the RPNAM.

The purpose of this study is to identify the frequency with which psychiatric nurses engage in specific relationship behaviours with their clients. n order to gain a clear understanding, it is important that a large number of RPNAM members respond to this survey. Enclosed are copies of a demographic questionnaire and a therapeutic practices survey. It will take approximately 20 minutes of your time to complete the questionnaire. Please complete both and return them in the enclosed envelope by June 1, 1996.

Return of the questionnaire will imply your consent to participate in this research study. You are under no obligation to complete this questionnaire. Your responses are **ABSOLUTELY ANONYMOUS**. I have no means of identifying respondents. The RPNAM will NOT have access to individual responses. Upon completion of the study, a summary of results will be included in the RPNAM newsletter that is sent to all members. If you have any further questions about this study you may contact myself or my advisor, Dr. Ray Henjum at the University of Manitoba, at 474-8740.

I would like to thank you for assisting me in completing my research. I look forward to providing you with the final results.

Sincerely,

Bernadine Desender

Demographic Questionnaire

1. Your Sex: (Circle number of your answer)

   1 Female
   2 Male

2. Your Age:____years

3. Current Marital Status (circle number of your answer):

   1 Married
   2 Cohabitating
   3 Single
   4 Divorced or Separated

4. Professional Designation (circle number of your answer):

   1 RPN
   2 RN
   3 Other (Please specify)_____

5. Are you currently involved in any advanced degree or specialization in mental health? (circle number of your answer)

   1 Yes
   2 No

   If so, for what degree or specialization?_____

6. Have you provided psychotherapy services at any time within the last 5 years? (circle number of your answer)

   1 Yes
   2 No

   If you responded Yes to question #6 please answer questions 7-11.

   If you responded no to question #6 please stop here and return questionnaire in the envelope provided.

7. Total number of years you have provided psychotherapy services since completing mental health training?

____Years

8. Many clinicians are guided by a number of theoretical orientations in their clinical work. Please indicate by circling the number of the following theoretical orientations which has most influenced your psychotherapy work.

1 Behavioral
2 Cognitive
3 Existential
4 Gestalt
5 Psychodynamic
6 Other (please specify)_____

9. In the past five years, what proportion of your clients have been: ____% youth (under 18)
____% adult men
____% adult women

____
100%

10. Which ONE of the following best describes the primary clinical setting in which you most recently provided psychotherapy services? (circle answer)

1 Solo Practice
2 Group Practice
3 Outpatient clinic
4 Inpatient Facility
5 Community
6 Other (please specify)_____

11. While working in that setting, how socially isolated do/did you feel? (Circle number of your answer)

1 Not at all isolated
2 Mildly isolated
3 Moderately isolated
4 Extremely isolated

12. Where do/did you reside while working at your previously indicated primary clinical setting? (circle number of your answer)

    1 I live(d) and work(ed) within the same small town or rural community

    2 I live(d) and work(ed) within the same urban town

    3 I live(d) and work(ed) in two different communities

13. How often do/did you unintentionally encounter current or former psychotherapy clients outside of therapy sessions? (circle number of your answer)

    1 EVERYDAY
    2 ONCE PER WEEK
    3 ONCE PER MONTH
    4 ONCE PER YEAR
    5 NEVER

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

Bernadine Desender
956 Alfred Avenue
Winnipeg, MB
R2X 0V2

THANK YOU!

Therapeutic Practices Survey

If your have provided counselling services at any time in the past 5 years, please complete both forms. If you have not provided counselling services in the past 5 years, complete only questions 1-6 on the demographic questionnaire.

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

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

Behaviours	Frequency of Behaviour When Opportunity Present					
	ALL CLIENTS	MOST CLIENTS	SOME CLIENTS	FEW CLIENTS	NO CLIENTS	NO OPPORTUNITY
Accepted a gift worth under $10 from a client	5	4	3	2	1	0
Accepted a client's invitation to a special occasion (eg. his/her wedding	5	4	3	2	1	0
Accepted a service or product as payment for therapy	5	4	3	2	1	0
Became friends with a client after termination	5	4	3	2	1	0
Sold a product to a client	5	4	3	2	1	0
Accepted a gift worth $50 from a client	5	4	3	2	1	0
Provided therapy to a then current employee	5	4	3	2	1	0
Engaged in sexual activity with a client after termination	5	4	3	2	1	0
Borrowed less than $5 from a client	5	4	3	2	1	0

Accepted a handshake offered by a client	5	4	3	2	1	0
Felt sexually attracted to a client	5	4	3	2	1	0
Disclosed details of your current personal stresses to a client	5	4	3	2	1	0
Borrowed over $20 from a client	5	4	3	2	1	0
Invited a client to an office/clinic open house	5	4	3	2	1	0
Employed a client	5	4	3	2	1	0
Went out to eat with a client after a session	5	4	3	2	1	0
Bought goods or services from a client	5	4	3	2	1	0
Engaged in sexual activity with a client you were treating either now or in the past	5	4	3	2	1	0
Invited clients to a personal party or social event	5	4	3	2	1	0
Provided individual therapy to a relative, friend, or lover of an on-going client	5	4	3	2	1	0
Provided therapy to a then current student or supervisee	5	4	3	2	1	0
Allowed a client to enrol in your class for a grade	5	4	3	2	1	0

If the return envelope is damaged or misplaced, please return survey to:
Bernadine Desender: 956 Alfred Avenue, Winnipeg, MB R2X 0V2
THANK YOU!

Appendix B

Reminder Card

Just a Reminder:

If you have not already returned your Demographic Questionnaire and the Therapeutic Practices Survey please do so by **June 24, 1996.**

If you have lost your return envelope send the questionnaires to:

B. Desender
956 Alfred Ave.
Winnipeg, MB
R2X 0V2

If you have already done so, **THANK YOU.**

Appendix C

Crosstabulation Data

Note:

Index	Category Number	Score
Incidental	1	0-3
	2	4-6
	3	7-9
	4	10-12
	5	13-15
Financial	1	0-5
	2	6-10
	3	11-15
	4	16-20
Social	1	1-8
	2	9-16
	3	17-24
	4	25-32
	5	32-40

Dual Roles--categories not used actual number indicated on crosstab data

Personal Totals	1	0-20
	2	21-30
	3	31-40
	4	41-55
	5	56-100

Other Grouped Data		Number of Years
Years of Counselling	1	1-5
	2	6-10
	3	11-15
	4	16-20
	5	21-30
Age	1	less than 25
	2	25-34
	3	35-44
	4	45-54
	5	55+

INCIDCAT by SEX1 sex

INCIDCAT	SEX1 female 1	SEX1 male 2	Row Total
1,00	88	22	110
	80,0	20,0	67,1
	68,8	61,1	
	53,7	13,4	
2,00	40	14	54
	74,1	25,9	32,9
	31,3	38,9	
	24,4	8,5	
Column Total	128	36	164
	78,0	22,0	100,0

FINCAT by SEX1 sex

FINCAT	SEX1 female 1	SEX1 male 2	Row Total
1,00	114	32	146
	78,1	21,9	89,0
	89,1	88,9	
	69,5	19,5	
2,00	14	3	17
	82,4	17,6	10,4
	10,9	8,3	
	8,5	1,8	
3,00		1	1
		100,0	,6
		2,8	
		,6	
Column Total	128	36	164
	78,0	22,0	100,0

DUALROLE by SEX1 sex

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	SEX1 female 1	SEX1 male 2	Row Total
0		25 80,6 19,5 15,2	6 19,4 16,7 3,7	31 18,9
1		12 80,0 9,4 7,3	3 20,0 8,3 1,8	15 9,1
2		15 88,2 11,7 9,1	2 11,8 5,6 1,2	17 10,4
3		18 81,8 14,1 11,0	4 18,2 11,1 2,4	22 13,4
4		29 70,7 22,7 17,7	12 29,3 33,3 7,3	41 25,0
5		12 70,6 9,4 7,3	5 29,4 13,9 3,0	17 10,4
6		10 100,0 7,8 6,1		10 6,1
7		6 75,0 4,7 3,7	2 25,0 5,6 1,2	8 4,9
(Continued)	Column Total	128 78,0	36 22,0	164 100,0

DUALROLE by SEX1 sex

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	SEX1 female 1	SEX1 male 2	Row Total
8			1 100,0 2,8 ,6	1 ,6
10		1 100,0 ,8 ,6		1 ,6
12			1 100,0 2,8 ,6	1 ,6
Column Total		128 78,0	36 22,0	164 100,0

SOCCAT by SEX1 sex

	SEX1		Page 1 of 1
Count Row Pct Col Pct Tot Pct	female	male	Row
SOCCAT	1	2	Total
1,00	84 80,8 68,9 53,5	20 19,2 57,1 12,7	104 66,2
2,00	38 73,1 31,1 24,2	14 26,9 40,0 8,9	52 33,1
4,00		1 100,0 2,9 ,6	1 ,6
Column Total	122 77,7	35 22,3	157 100,0

PRTOTCAT by SEX1 sex

	SEX1		Page 1 of 1
Count Row Pct Col Pct Tot Pct	female	male	Row
PRTOTCAT	1	2	Total
1,00	80 82,5 65,6 51,0	17 17,5 48,6 10,8	97 61,8
2,00	40 71,4 32,8 25,5	16 28,6 45,7 10,2	56 35,7
3,00	2 66,7 1,6 1,3	1 33,3 2,9 ,6	3 1,9
4,00		1 100,0 2,9 ,6	1 ,6
Column Total	122 77,7	35 22,3	157 100,0

INCIDCAT by AGE2 age2

Page 1 of 1

INCIDCAT	Count / Row Pct / Col Pct / Tot Pct	AGE2 1	2	3	4	5	Row Total
1,00		6	36	35	27	4	108
		5,6	33,3	32,4	25,0	3,7	67,1
		85,7	78,3	53,8	71,1	80,0	
		3,7	22,4	21,7	16,8	2,5	
2,00		1	10	30	11	1	53
		1,9	18,9	56,6	20,8	1,9	32,9
		14,3	21,7	46,2	28,9	20,0	
		,6	6,2	18,6	6,8	,6	
Column Total		7	46	65	38	5	161
		4,3	28,6	40,4	23,6	3,1	100,0

FINCAT by AGE2 age2

Page 1 of 1

FINCAT	Count / Row Pct / Col Pct / Tot Pct	AGE2 1	2	3	4	5	Row Total
1,00		7	40	57	34	5	143
		4,9	28,0	39,9	23,8	3,5	88,8
		100,0	87,0	87,7	89,5	100,0	
		4,3	24,8	35,4	21,1	3,1	
2,00			5	8	4		17
			29,4	47,1	23,5		10,6
			10,9	12,3	10,5		
			3,1	5,0	2,5		
3,00			1				1
			100,0				,6
			2,2				
			,6				
Column Total		7	46	65	38	5	161
		4,3	28,6	40,4	23,6	3,1	100,0

DUALROLE by AGE2 age2

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	AGE2 1	2	3	4	5	Row Total
0		1 3,3 14,3 ,6	12 40,0 26,1 7,5	8 26,7 12,3 5,0	8 26,7 21,1 5,0	1 3,3 20,0 ,6	30 18,6
1		1 6,7 14,3 ,6	6 40,0 13,0 3,7	6 40,0 9,2 3,7	2 13,3 5,3 1,2		15 9,3
2		1 5,9 14,3 ,6	5 29,4 10,9 3,1	8 47,1 12,3 5,0	2 11,8 5,3 1,2	1 5,9 20,0 ,6	17 10,6
3			5 23,8 10,9 3,1	9 42,9 13,8 5,6	5 23,8 13,2 3,1	2 9,5 40,0 1,2	21 13,0
4		2 5,0 28,6 1,2	11 27,5 23,9 6,8	15 37,5 23,1 9,3	11 27,5 28,9 6,8	1 2,5 20,0 ,6	40 24,8
5		1 5,9 14,3 ,6	3 17,6 6,5 1,9	10 58,8 15,4 6,2	3 17,6 7,9 1,9		17 10,6
6		1 10,0 14,3 ,6	2 20,0 4,3 1,2	5 50,0 7,7 3,1	2 20,0 5,3 1,2		10 6,2
7			1 12,5 2,2 ,6	3 37,5 4,6 1,9	4 50,0 10,5 2,5		8 5,0
(Continued)	Column Total	7 4,3	46 28,6	65 40,4	38 23,6	5 3,1	161 100,0

DUALROLE by AGE2 age2

DUALROLE	AGE2 1	2	3	4	5	Row Total
8				1 100,0 2,6 ,6		1 ,6
10			1 100,0 1,5 ,6			1 ,6
12		1 100,0 2,2 ,6				1 ,6
Column Total	7 4,3	46 28,6	65 40,4	38 23,6	5 3,1	161 100,0

SOCCAT by AGE2 age2

SOCCAT	AGE2 1	2	3	4	5	Row Total
1,00	5 5,0 71,4 3,2	32 31,7 69,6 20,8	40 39,6 63,5 26,0	21 20,8 63,6 13,6	3 3,0 60,0 1,9	101 65,6
2,00	2 3,8 28,6 1,3	13 25,0 28,3 8,4	23 44,2 36,5 14,9	12 23,1 36,4 7,8	2 3,8 40,0 1,3	52 33,8
4,00		1 100,0 2,2 ,6				1 ,6
Column Total	7 4,5	46 29,9	63 40,9	33 21,4	5 3,2	154 100,0

PRTOTCAT by AGE2 age2

PRTOTCAT	AGE2 1	2	3	4	5	Row Total
1,00	4 4,2 57,1 2,6	32 33,7 69,6 20,8	37 38,9 58,7 24,0	18 18,9 54,5 11,7	4 4,2 80,0 2,6	95 61,7
2,00	3 5,5 42,9 1,9	13 23,6 28,3 8,4	24 43,6 38,1 15,6	14 25,5 42,4 9,1	1 1,8 20,0 ,6	55 35,7
3,00			2 66,7 3,2 1,3	1 33,3 3,0 ,6		3 1,9
4,00		1 100,0 2,2 ,6				1 ,6
Column Total	7 4,5	46 29,9	63 40,9	33 21,4	5 3,2	154 100,0

INCIDCAT by MARITAL3 marital status

	MARITAL3				Page 1 of 1
INCIDCAT	Count Row Pct Col Pct Tot Pct	married 1	cohabiting 2	single 3	divorced or sepa 4	Row Total
1,00		82 74,5 69,5 50,0	6 5,5 54,5 3,7	12 10,9 63,2 7,3	10 9,1 62,5 6,1	110 67,1
2,00		36 66,7 30,5 22,0	5 9,3 45,5 3,0	7 13,0 36,8 4,3	6 11,1 37,5 3,7	54 32,9
Column Total		118 72,0	11 6,7	19 11,6	16 9,8	164 100,0

FINCAT by MARITAL3 marital status

	MARITAL3				Page 1 of 1
FINCAT	Count Row Pct Col Pct Tot Pct	married 1	cohabiting 2	single 3	divorced or sepa 4	Row Total
1,00		103 70,5 87,3 62,8	10 6,8 90,9 6,1	18 12,3 94,7 11,0	15 10,3 93,8 9,1	146 89,0
2,00		14 82,4 11,9 8,5	1 5,9 9,1 ,6	1 5,9 5,3 ,6	1 5,9 6,3 ,6	17 10,4
3,00		1 100,0 ,8 ,6				1 ,6
Column Total		118 72,0	11 6,7	19 11,6	16 9,8	164 100,0

DUALROLE by MARITAL3 marital status

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	MARITAL3 married 1	cohabiting 2	single 3	divorced or sepa 4	Row Total
0		23 74,2 19,5 14,0	1 3,2 9,1 ,6	5 16,1 26,3 3,0	2 6,5 12,5 1,2	31 18,9
1		12 80,0 10,2 7,3	1 6,7 9,1 ,6	2 13,3 10,5 1,2		15 9,1
2		12 70,6 10,2 7,3	3 17,6 27,3 1,8	2 11,8 10,5 1,2		17 10,4
3		15 68,2 12,7 9,1	1 4,5 9,1 ,6	3 13,6 15,8 1,8	3 13,6 18,8 1,8	22 13,4
4		29 70,7 24,6 17,7	2 4,9 18,2 1,2	4 9,8 21,1 2,4	6 14,6 37,5 3,7	41 25,0
5		11 64,7 9,3 6,7	2 11,8 18,2 1,2	1 5,9 5,3 ,6	3 17,6 18,8 1,8	17 10,4
6		8 80,0 6,8 4,9		1 10,0 5,3 ,6	1 10,0 6,3 ,6	10 6,1
7		6 75,0 5,1 3,7	1 12,5 9,1 ,6	1 12,5 5,3 ,6		8 4,9
(Continued)	Column Total	118 72,0	11 6,7	19 11,6	16 9,8	164 100,0

DUALROLE by MARITAL3 marital status

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	MARITAL3 married 1	cohabiting 2	single 3	divorced or sepa 4	Row Total
8		1 100,0 ,8 ,6				1 ,6
10					1 100,0 6,3 ,6	1 ,6
12		1 100,0 ,8 ,6				1 ,6
Column Total		118 72,0	11 6,7	19 11,6	16 9,8	164 100,0

SOCCAT by MARITAL3 marital status

SOCCAT	Count / Row Pct / Col Pct / Tot Pct	MARITAL3 married 1	cohabiting 2	single 3	divorced or sepa 4	Row Total
1,00		78 75,0 67,8 49,7	6 5,8 54,5 3,8	13 12,5 72,2 8,3	7 6,7 53,8 4,5	104 66,2
2,00		36 69,2 31,3 22,9	5 9,6 45,5 3,2	5 9,6 27,8 3,2	6 11,5 46,2 3,8	52 33,1
4,00		1 100,0 ,9 ,6				1 ,6
Column Total		115 73,2	11 7,0	18 11,5	13 8,3	157 100,0

PRTOTCAT by MARITAL3 marital status

PRTOTCAT	Count / Row Pct / Col Pct / Tot Pct	MARITAL3 married 1	cohabiting 2	single 3	divorced or sepa 4	Row Total
1,00		73 75,3 63,5 46,5	6 6,2 54,5 3,8	12 12,4 66,7 7,6	6 6,2 46,2 3,8	97 61,8
2,00		40 71,4 34,8 25,5	4 7,1 36,4 2,5	6 10,7 33,3 3,8	6 10,7 46,2 3,8	56 35,7
3,00		1 33,3 ,9 ,6	1 33,3 9,1 ,6		1 33,3 7,7 ,6	3 1,9
4,00		1 100,0 ,9 ,6				1 ,6
Column Total		115 73,2	11 7,0	18 11,5	13 8,3	157 100,0

INCIDCAT by PROFESS4 professional designation

INCIDCAT	PROFESS4 rpn only 1	PROFESS4 rph and higher e 2	Row Total
1,00	83 75,5 69,2 50,6	27 24,5 61,4 16,5	110 67,1
2,00	37 68,5 30,8 22,6	17 31,5 38,6 10,4	54 32,9
Column Total	120 73,2	44 26,8	164 100,0

Page 1 of 1

FINCAT by PROFESS4 professional designation

FINCAT	PROFESS4 rpn only 1	PROFESS4 rph and higher e 2	Row Total
1,00	110 75,3 91,7 67,1	36 24,7 81,8 22,0	146 89,0
2,00	9 52,9 7,5 5,5	8 47,1 18,2 4,9	17 10,4
3,00	1 100,0 ,8 ,6		1 .,6
Column Total	120 73,2	44 26,8	164 100,0

Page 1 of 1

DUALROLE by PROFESS4 professional designation

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	PROFESS4 rpn only 1	rph and higher e 2	Row Total
0		20 64,5 16,7 12,2	11 35,5 25,0 6,7	31 18,9
1		12 80,0 10,0 7,3	3 20,0 6,8 1,8	15 9,1
2		11 64,7 9,2 6,7	6 35,3 13,6 3,7	17 10,4
3		20 90,9 16,7 12,2	2 9,1 4,5 1,2	22 13,4
4		32 78,0 26,7 19,5	9 22,0 20,5 5,5	41 25,0
5		12 70,6 10,0 7,3	5 29,4 11,4 3,0	17 10,4
6		5 50,0 4,2 3,0	5 50,0 11,4 3,0	10 6,1
7		5 62,5 4,2 3,0	3 37,5 6,8 1,8	8 4,9
(Continued)	Column Total	120 73,2	44 26,8	164 100,0

DUALROLE by PROFESS4 professional designation

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	PROFESS4 rpn only 1	PROFESS4 rph and higher e 2	Row Total
8		1 100,0 ,8 ,6		1 ,6
10		1 100,0 ,8 ,6		1 ,6
12		1 100,0 ,8 ,6		1 ,6
Column Total		120 73,2	44 26,8	164 100,0

SOCCAT by PROFESS4 professional designation

PROFESS4 Page 1 of 1

SOCCAT	Count / Row Pct / Col Pct / Tot Pct	rpn only 1	rph and higher e 2	Row Total
1,00		76 73,1 66,7 48,4	28 26,9 65,1 17,8	104 66,2
2,00		37 71,2 32,5 23,6	15 28,8 34,9 9,6	52 33,1
4,00		1 100,0 ,9 ,6		1 ,6
Column Total		114 72,6	43 27,4	157 100,0

PRTOTCAT by PROFESS4 professional designation

PROFESS4 Page 1 of 1

PRTOTCAT	Count / Row Pct / Col Pct / Tot Pct	rpn only 1	rph and higher e 2	Row Total
1,00		73 75,3 64,0 46,5	24 24,7 55,8 15,3	97 61,8
2,00		38 67,9 33,3 24,2	18 32,1 41,9 11,5	56 35,7
3,00		2 66,7 1,8 1,3	1 33,3 2,3 ,6	3 1,9
4,00		1 100,0 ,9 ,6		1 ,6
Column Total		114 72,6	43 27,4	157 100,0

INCIDCAT by ADVDEG5 currently involved in advance degree in

ADVDEG5 Page 1 of 1

INCIDCAT	yes 1	no 2	Row Total
1,00	20 18,3 58,8 12,3	89 81,7 69,5 54,9	109 67,3
2,00	14 26,4 41,2 8,6	39 73,6 30,5 24,1	53 32,7
Column Total	34 21,0	128 79,0	162 100,0

FINCAT by ADVDEG5 currently involved in advance degree in

ADVDEG5 Page 1 of 1

FINCAT	yes 1	no 2	Row Total
1,00	32 22,2 94,1 19,8	112 77,8 87,5 69,1	144 88,9
2,00	1 5,9 2,9 ,6	16 94,1 12,5 9,9	17 10,5
3,00	1 100,0 2,9 ,6		1 ,6
Column Total	34 21,0	128 79,0	162 100,0

DUALROLE by ADVDEG5 currently involved in advance degree in

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	ADVDEG5 yes 1	ADVDEG5 no 2	Row Total
0		5 16,1 14,7 3,1	26 83,9 20,3 16,0	31 19,1
1		4 26,7 11,8 2,5	11 73,3 8,6 6,8	15 9,3
2		4 23,5 11,8 2,5	13 76,5 10,2 8,0	17 10,5
3		6 28,6 17,6 3,7	15 71,4 11,7 9,3	21 13,0
4		9 22,5 26,5 5,6	31 77,5 24,2 19,1	40 24,7
5		4 23,5 11,8 2,5	13 76,5 10,2 8,0	17 10,5
6		1 10,0 2,9 ,6	9 90,0 7,0 5,6	10 6,2
7			8 100,0 6,3 4,9	8 4,9
(Continued)	Column Total	34 21,0	128 79,0	162 100,0

DUALROLE by ADVDEG5 currently involved in advance degree in

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	ADVDEG5 yes 1	ADVDEG5 no 2	Row Total
8			1 100,0 ,8 ,6	1 ,6
10			1 100,0 ,8 ,6	1 ,6
12		1 100,0 2,9 ,6		1 ,6
Column Total		34 21,0	128 79,0	162 100,0

SOCCAT by ADVDEG5 currently involved in advance degree in

ADVDEG5 Page 1 of 1

SOCCAT	yes 1	no 2	Row Total
1,00	21 20,6 63,6 13,5	81 79,4 66,4 52,3	102 65,8
2,00	11 21,2 33,3 7,1	41 78,8 33,6 26,5	52 33,5
4,00	1 100,0 3,0 ,6		1 ,6
Column Total	33 21,3	122 78,7	155 100,0

PRTOTCAT by ADVDEG5 currently involved in advance degree in

ADVDEG5 Page 1 of 1

PRTOTCAT	yes 1	no 2	Row Total
1,00	21 21,9 63,6 13,5	75 78,1 61,5 48,4	96 61,9
2,00	11 20,0 33,3 7,1	44 80,0 36,1 28,4	55 35,5
3,00		3 100,0 2,5 1,9	3 1,9
4,00	1 100,0 3,0 ,6		1 ,6
Column Total	33 21,3	122 78,7	155 100,0

INCIDCAT by YRSCAT

INCIDCAT	Count / Row Pct / Col Pct / Tot Pct	YRSCAT 1,00	2,00	3,00	4,00	5,00	Row Total
1,00		41	25	15	10	14	105
		39,0	23,8	14,3	9,5	13,3	68,2
		82,0	71,4	46,9	62,5	66,7	
		26,6	16,2	9,7	6,5	9,1	
2,00		9	10	17	6	7	49
		18,4	20,4	34,7	12,2	14,3	31,8
		18,0	28,6	53,1	37,5	33,3	
		5,8	6,5	11,0	3,9	4,5	
Column Total		50	35	32	16	21	154
		32,5	22,7	20,8	10,4	13,6	100,0

FINCAT by YRSCAT

FINCAT	Count / Row Pct / Col Pct / Tot Pct	YRSCAT 1,00	2,00	3,00	4,00	5,00	Row Total
1,00		48	29	27	13	19	136
		35,3	21,3	19,9	9,6	14,0	88,3
		96,0	82,9	84,4	81,3	90,5	
		31,2	18,8	17,5	8,4	12,3	
2,00		1	6	5	3	2	17
		5,9	35,3	29,4	17,6	11,8	11,0
		2,0	17,1	15,6	18,8	9,5	
		,6	3,9	3,2	1,9	1,3	
3,00		1					1
		100,0					,6
		2,0					
		,6					
Column Total		50	35	32	16	21	154
		32,5	22,7	20,8	10,4	13,6	100,0

DUALROLE by YRSCOUN7 no. of yrs provided counsel services sin

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	YRSCOUN7 1	2	3	4	5	Row Total
0		5 16,7 29,4 3,2	1 3,3 11,1 ,6	4 13,3 57,1 2,6	1 3,3 14,3 ,6	2 6,7 20,0 1,3	30 19,4
1		1 6,7 5,9 ,6	1 6,7 11,1 ,6	1 6,7 14,3 ,6	2 13,3 28,6 1,3	2 13,3 20,0 1,3	15 9,7
2		4 23,5 23,5 2,6			1 5,9 14,3 ,6	1 5,9 10,0 ,6	17 11,0
3		1 5,0 5,9 ,6	1 5,0 11,1 ,6		1 5,0 14,3 ,6	3 15,0 30,0 1,9	20 12,9
4		4 10,8 23,5 2,6	1 2,7 11,1 ,6	2 5,4 28,6 1,3	1 2,7 14,3 ,6	1 2,7 10,0 ,6	37 23,9
5		1 6,3 5,9 ,6	4 25,0 44,4 2,6		1 6,3 14,3 ,6		16 10,3
6		1 11,1 5,9 ,6	1 11,1 11,1 ,6				9 5,8
7							8 5,2
(Continued)	Column Total	17 11,0	9 5,8	7 4,5	7 4,5	10 6,5	155 100,0

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	YRSCOUN7 6	7	8	9	10	Row Total
	0	2 6,7 28,6 1,3		3 10,0 33,3 1,9	1 3,3 33,3 ,6	4 13,3 30,8 2,6	30 19,4
	1				1 6,7 33,3 ,6	1 6,7 7,7 ,6	15 9,7
	2	1 5,9 14,3 ,6		2 11,8 22,2 1,3		2 11,8 15,4 1,3	17 11,0
	3			1 5,0 11,1 ,6		2 10,0 15,4 1,3	20 12,9
	4	2 5,4 28,6 1,3	3 8,1 100,0 1,9	1 2,7 11,1 ,6	1 2,7 33,3 ,6	1 2,7 7,7 ,6	37 23,9
	5	1 6,3 14,3 ,6		1 6,3 11,1 ,6		2 12,5 15,4 1,3	16 10,3
	6			1 11,1 11,1 ,6		1 11,1 7,7 ,6	9 5,8
	7	1 12,5 14,3 ,6					8 5,2
(Continued)	Column Total	7 4,5	3 1,9	9 5,8	3 1,9	13 8,4	155 100,0

DUALROLE by YRSCOUN7 no. of yrs provided counsel services sin

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	YRSCOUN7 11	12	13	14	15	Row Total
0					1 3,3 16,7 ,6		30 19,4
1		1 6,7 16,7 ,6	2 13,3 22,2 1,3				15 9,7
2			1 5,9 11,1 ,6	1 5,9 12,5 ,6	1 5,9 16,7 ,6		17 11,0
3		1 5,0 16,7 ,6		1 5,0 12,5 ,6		1 5,0 33,3 ,6	20 12,9
4		1 2,7 16,7 ,6	4 10,8 44,4 2,6	4 10,8 50,0 2,6	3 8,1 50,0 1,9	2 5,4 66,7 1,3	37 23,9
5		1 6,3 16,7 ,6		1 6,3 12,5 ,6	1 6,3 16,7 ,6		16 10,3
6		1 11,1 16,7 ,6		1 11,1 12,5 ,6			9 5,8
7			2 25,0 22,2 1,3				8 5,2
(Continued)	Column Total	6 3,9	9 5,8	8 5,2	6 3,9	3 1,9	155 100,0

DUALROLE by YRSCOUN7 no. of yrs provided counsel services sin

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	YRSCOUN7 16	17	18	19	20	Row Total
	0				1 3,3 25,0 ,6		30 19,4
	1		1 6,7 33,3 ,6	.		1 6,7 20,0 ,6	15 9,7
	2					1 5,9 20,0 ,6	17 11,0
	3	2 10,0 66,7 1,3			1 5,0 25,0 ,6	1 5,0 20,0 ,6	20 12,9
	4		2 5,4 66,7 1,3	1 2,7 100,0 ,6	1 2,7 25,0 ,6	1 2,7 20,0 ,6	37 23,9
	5					.	16 10,3
	6	1 11,1 33,3 ,6					9 5,8
	7				1 12,5 25,0 ,6	1 12,5 20,0 ,6	8 5,2
(Continued)	Column Total	3 1,9	3 1,9	1 ,6	4 2,6	5 3,2	155 100,0

DUALROLE by YRSCOUN7 no. of yrs provided counsel services sin

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	YRSCOUN7 21	22	23	25	26	Row Total
0			1 3,3 25,0 ,6		1 3,3 33,3 ,6	1 3,3 25,0 ,6	30 19,4
1			1 6,7 25,0 ,6				15 9,7
2			1 5,9 25,0 ,6		1 5,9 33,3 ,6		17 11,0
3		1 5,0 50,0 ,6		1 5,0 100,0 ,6		1 5,0 25,0 ,6	20 12,9
4							37 23,9
5		1 6,3 50,0 ,6					16 10,3
6			1 11,1 25,0 ,6				9 5,8
7					1 12,5 33,3 ,6	2 25,0 50,0 1,3	8 5,2
(Continued)	Column Total	2 1,3	4 2,6	1 ,6	3 1,9	4 2,6	155 100,0

DUALROLE by YRSCOUN7 no. of yrs provided counsel services sin

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	YRSCOUN7 28	30	32	55	Row Total
0			2 6,7 50,0 1,3			30 19,4
1						15 9,7
2						17 11,0
3				1 5,0 100,0 ,6		20 12,9
4			1 2,7 25,0 ,6			37 23,9
5		1 6,3 50,0 ,6			1 6,3 100,0 ,6	16 10,3
6		1 11,1 50,0 ,6				9 5,8
7						8 5,2
(Continued)	Column Total	2 1,3	4 2,6	1 ,6	1 ,6	155 100,0

DUALROLE by YRSCOUN7 no. of yrs provided counsel services sin

DUALROLE	YRSCOUN7 1	2	3	4	5	Row Total
8						1 ,6
10						1 ,6
12					1 100,0 10,0 ,6	1 ,6
Column Total	17 11,0	9 5,8	7 4,5	7 4,5	10 6,5	155 100,0

(Continued)

DUALROLE by YRSCOUN7 no. of yrs provided counsel services sin

DUALROLE	YRSCOUN7 6	7	8	9	10	Row Total
8						1 ,6
10						1 ,6
12						1 ,6
Column Total	7 4,5	3 1,9	9 5,8	3 1,9	13 8,4	155 100,0

(Continued)

DUALROLE by YRSCOUN7 no. of yrs provided counsel services sin

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	YRSCOUN7 11	12	13	14	15	Row Total
8							1 ,6
10		1 100,0 16,7 ,6					1 ,6
12							1 ,6
Column Total		6 3,9	9 5,8	8 5,2	6 3,9	3 1,9	155 100,0

(Continued)

DUALROLE by YRSCOUN7 no. of yrs provided counsel services sin

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	YRSCOUN7 16	17	18	19	20	Row Total
8							1 ,6
10							1 ,6
12							1 ,6
Column Total		3 1,9	3 1,9	1 ,6	4 2,6	5 3,2	155 100,0

(Continued)

DUALROLE by YRSCOUN7 no. of yrs provided counsel services sin

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	YRSCOUN7 21	22	23	25	26	Row Total
	8						1 ,6
	10						1 ,6
	12						1 ,6
(Continued)	Column Total	2 1,3	4 2,6	1 ,6	3 1,9	4 2,6	155 100,0

DUALROLE by YRSCOUN7 no. of yrs provided counsel services sin

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	YRSCOUN7 28	30	32	55	Row Total
	8		1 100,0 25,0 ,6			1 ,6
	10					1 ,6
	12					1 ,6
	Column Total	2 1,3	4 2,6	1 ,6	1 ,6	155 100,0

SOCCAT by YRSCAT

SOCCAT	Count / Row Pct / Col Pct / Tot Pct	YRSCAT 1,00	2,00	3,00	4,00	5,00	Row Total
1,00		38 39,2 80,9 25,7	23 23,7 65,7 15,5	15 15,5 46,9 10,1	9 9,3 56,3 6,1	12 12,4 66,7 8,1	97 65,5
2,00		8 16,0 17,0 5,4	12 24,0 34,3 8,1	17 34,0 53,1 11,5	7 14,0 43,8 4,7	6 12,0 33,3 4,1	50 33,8
4,00		1 100,0 2,1 ,7					1 ,7
Column Total		47 31,8	35 23,6	32 21,6	16 10,8	18 12,2	148 100,0

PRTOTCAT by YRSCAT

PRTOTCAT	Count / Row Pct / Col Pct / Tot Pct	YRSCAT 1,00	2,00	3,00	4,00	5,00	Row Total
1,00		38 40,9 80,9 25,7	23 24,7 65,7 15,5	13 14,0 40,6 8,8	10 10,8 62,5 6,8	9 9,7 50,0 6,1	93 62,8
2,00		8 15,7 17,0 5,4	11 21,6 31,4 7,4	18 35,3 56,3 12,2	5 9,8 31,3 3,4	9 17,6 50,0 6,1	51 34,5
3,00			1 33,3 2,9 ,7	1 33,3 3,1 ,7	1 33,3 6,3 ,7		3 2,0
4,00		1 100,0 2,1 ,7					1 ,7
Column Total		47 31,8	35 23,6	32 21,6	16 10,8	18 12,2	148 100,0

INCIDCAT by CLIENT9T majority of clients

INCIDCAT	CLIENT9T men 1	women 2	equal 3	youths 4	Row Total
1,00	29 27,1 80,6 18,2	35 32,7 58,3 22,0	25 23,4 71,4 15,7	18 16,8 64,3 11,3	107 67,3
2,00	7 13,5 19,4 4,4	25 48,1 41,7 15,7	10 19,2 28,6 6,3	10 19,2 35,7 6,3	52 32,7
Column Total	36 22,6	60 37,7	35 22,0	28 17,6	159 100,0

FINCAT by CLIENT9T majority of clients

FINCAT	CLIENT9T men 1	women 2	equal 3	youths 4	Row Total
1,00	32 22,7 88,9 20,1	53 37,6 88,3 33,3	32 22,7 91,4 20,1	24 17,0 85,7 15,1	141 88,7
2,00	4 23,5 11,1 2,5	7 41,2 11,7 4,4	3 17,6 8,6 1,9	3 17,6 10,7 1,9	17 10,7
3,00				1 100,0 3,6 ,6	1 ,6
Column Total	36 22,6	60 37,7	35 22,0	28 17,6	159 100,0

DUALROLE by CLIENT9T majority of clients

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	CLIENT9T men 1	women 2	equal 3	youths 4	Row Total
0		7 23,3 19,4 4,4	12 40,0 20,0 7,5	6 20,0 17,1 3,8	5 16,7 17,9 3,1	30 18,9
1		7 46,7 19,4 4,4	3 20,0 5,0 1,9	2 13,3 5,7 1,3	3 20,0 10,7 1,9	15 9,4
2		1 5,9 2,8 ,6	10 58,8 16,7 6,3	4 23,5 11,4 2,5	2 11,8 7,1 1,3	17 10,7
3		3 14,3 8,3 1,9	6 28,6 10,0 3,8	7 33,3 20,0 4,4	5 23,8 17,9 3,1	21 13,2
4		11 28,9 30,6 6,9	8 21,1 13,3 5,0	12 31,6 34,3 7,5	7 18,4 25,0 4,4	38 23,9
5		2 11,8 5,6 1,3	10 58,8 16,7 6,3	1 5,9 2,9 ,6	4 23,5 14,3 2,5	17 10,7
6		3 30,0 8,3 1,9	4 40,0 6,7 2,5	2 20,0 5,7 1,3	1 10,0 3,6 ,6	10 6,3
7		1 12,5 2,8 ,6	6 75,0 10,0 3,8	1 12,5 2,9 ,6		8 5,0
(Continued)	Column Total	36 22,6	60 37,7	35 22,0	28 17,6	159 100,0

DUALROLE by CLIENT9T majority of clients

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	CLIENT9T men 1	women 2	equal 3	youths 4	Row Total
8			1 100,0 1,7 ,6			1 ,6
10		1 100,0 2,8 ,6				1 ,6
12					1 100,0 3,6 ,6	1 ,6
Column Total		36 22,6	60 37,7	35 22,0	28 17,6	159 100,0

SOCCAT by CLIENT9T majority of clients

SOCCAT	CLIENT9T men 1	women 2	equal 3	youths 4	Row Total
1,00	23 22,8 67,6 15,1	35 34,7 60,3 23,0	23 22,8 69,7 15,1	20 19,8 74,1 13,2	101 66,4
2,00	11 22,0 32,4 7,2	23 46,0 39,7 15,1	10 20,0 30,3 6,6	6 12,0 22,2 3,9	50 32,9
4,00				1 100,0 3,7 ,7	1 ,7
Column Total	34 22,4	58 38,2	33 21,7	27 17,8	152 100,0

PRTOTCAT by CLIENT9T majority of clients

PRTOTCAT	CLIENT9T men 1	women 2	equal 3	youths 4	Row Total
1,00	23 24,5 67,6 15,1	34 36,2 58,6 22,4	20 21,3 60,6 13,2	17 18,1 63,0 11,2	94 61,8
2,00	11 20,4 32,4 7,2	21 38,9 36,2 13,8	13 24,1 39,4 8,6	9 16,7 33,3 5,9	54 35,5
3,00		3 100,0 5,2 2,0			3 2,0
4,00				1 100,0 3,7 ,7	1 ,7
Column Total	34 22,4	58 38,2	33 21,7	27 17,8	152 100,0

INCIDCAT by CLINIC10 primary clinical setting

INCIDCAT	CLINIC10					
Count / Row Pct / Col Pct / Tot Pct	solo practice 1	outpatient clinic 3	inpatient clinic 4	community clinic 5	other 6	Row Total
1,00	5 4,9 62,5 3,3	3 2,9 42,9 2,0	53 51,5 75,7 34,9	33 32,0 60,0 21,7	9 8,7 75,0 5,9	103 67,8
2,00	3 6,1 37,5 2,0	4 8,2 57,1 2,6	17 34,7 24,3 11,2	22 44,9 40,0 14,5	3 6,1 25,0 2,0	49 32,2
Column Total	8 5,3	7 4,6	70 46,1	55 36,2	12 7,9	152 100,0

FINCAT by CLINIC10 primary clinical setting

FINCAT	CLINIC10					
Count / Row Pct / Col Pct / Tot Pct	solo practice 1	outpatient clinic 3	inpatient clinic 4	community clinic 5	other 6	Row Total
1,00	8 5,9 100,0 5,3	4 3,0 57,1 2,6	63 46,7 90,0 41,4	51 37,8 92,7 33,6	9 6,7 75,0 5,9	135 88,8
2,00		3 18,8 42,9 2,0	7 43,8 10,0 4,6	4 25,0 7,3 2,6	2 12,5 16,7 1,3	16 10,5
3,00					1 100,0 8,3 ,7	1 ,7
Column Total	8 5,3	7 4,6	70 46,1	55 36,2	12 7,9	152 100,0

DUALROLE by CLINIC10 primary clinical setting

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	CLINIC10 solo practice 1	outpatient clinic 3	inpatient clinic 4	community clinic 5	other 6	Row Total
0		2 6,9 25,0 1,3		14 48,3 20,0 9,2	9 31,0 16,4 5,9	4 13,8 33,3 2,6	29 19,1
1				9 64,3 12,9 5,9	5 35,7 9,1 3,3		14 9,2
2				7 43,8 10,0 4,6	7 43,8 12,7 4,6	2 12,5 16,7 1,3	16 10,5
3		2 10,0 25,0 1,3		13 65,0 18,6 8,6	5 25,0 9,1 3,3		20 13,2
4		2 5,4 25,0 1,3	5 13,5 71,4 3,3	16 43,2 22,9 10,5	10 27,0 18,2 6,6	4 10,8 33,3 2,6	37 24,3
5		1 6,3 12,5 ,7		5 31,3 7,1 3,3	10 62,5 18,2 6,6		16 10,5
6		1 11,1 12,5 ,7	2 22,2 28,6 1,3	4 44,4 5,7 2,6	2 22,2 3,6 1,3		9 5,9
7				2 25,0 2,9 1,3	5 62,5 9,1 3,3	1 12,5 8,3 ,7	8 5,3
(Continued)	Column Total	8 5,3	7 4,6	70 46,1	55 36,2	12 7,9	152 100,0

DUALROLE by CLINIC10 primary clinical setting

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	CLINIC10 solo practice 1	outpatient clinic 3	inpatient clinic 4	community clinic 5	other 6	Row Total
8					1 100,0 1,8 ,7		1 ,7
10					1 100,0 1,8 ,7		1 ,7
12						1 100,0 8,3 ,7	1 ,7
Column Total		8 5,3	7 4,6	70 46,1	55 36,2	12 7,9	152 100,0

SOCCAT by CLINIC10 primary clinical setting

CLINIC10 Page 1 of 1

SOCCAT	Count / Row Pct / Col Pct / Tot Pct	solo practice 1	outpatient clinic 3	inpatient clinic 4	community y 5	other 6	Row Total
1,00		6 6,1 75,0 4,1	2 2,0 28,6 1,4	47 47,5 68,1 32,0	34 34,3 66,7 23,1	10 10,1 83,3 6,8	99 67,3
2,00		2 4,3 25,0 1,4	5 10,6 71,4 3,4	22 46,8 31,9 15,0	17 36,2 33,3 11,6	1 2,1 8,3 ,7	47 32,0
4,00						1 100,0 8,3 ,7	1 ,7
Column Total		8 5,4	7 4,8	69 46,9	51 34,7	12 8,2	147 100,0

PRTOTCAT by CLINIC10 primary clinical setting

CLINIC10 Page 1 of 1

PRTOTCAT	Count / Row Pct / Col Pct / Tot Pct	solo practice 1	outpatient clinic 3	inpatient clinic 4	community y 5	other 6	Row Total
1,00		5 5,4 62,5 3,4	1 1,1 14,3 ,7	48 52,2 69,6 32,7	29 31,5 56,9 19,7	9 9,8 75,0 6,1	92 62,6
2,00		3 5,9 37,5 2,0	5 9,8 71,4 3,4	20 39,2 29,0 13,6	21 41,2 41,2 14,3	2 3,9 16,7 1,4	51 34,7
3,00			1 33,3 14,3 ,7	1 33,3 1,4 ,7	1 33,3 2,0 ,7		3 2,0
4,00						1 100,0 8,3 ,7	1 ,7
Column Total		8 5,4	7 4,8	69 46,9	51 34,7	12 8,2	147 100,0

INCIDCAT by ISOLAT11 in that setting how socially isolated

ISOLAT11 Page 1 of 1

INCIDCAT	Count / Row Pct / Col Pct / Tot Pct	not at all isolated 1	mildly isolated 2	moderately isolated 3	extremely isolated 4	Row Total
1,00		50	32	23	2	107
		46,7	29,9	21,5	1,9	66,9
		66,7	65,3	76,7	33,3	
		31,3	20,0	14,4	1,3	
2,00		25	17	7	4	53
		47,2	32,1	13,2	7,5	33,1
		33,3	34,7	23,3	66,7	
		15,6	10,6	4,4	2,5	
Column Total		75	49	30	6	160
		46,9	30,6	18,8	3,8	100,0

FINCAT by ISOLAT11 in that setting how socially isolated

ISOLAT11 Page 1 of 1

FINCAT	Count / Row Pct / Col Pct / Tot Pct	not at all isolated 1	mildly isolated 2	moderately isolated 3	extremely isolated 4	Row Total
1,00		68	45	25	4	142
		47,9	31,7	17,6	2,8	88,8
		90,7	91,8	83,3	66,7	
		42,5	28,1	15,6	2,5	
2,00		7	3	5	2	17
		41,2	17,6	29,4	11,8	10,6
		9,3	6,1	16,7	33,3	
		4,4	1,9	3,1	1,3	
3,00			1			1
			100,0			,6
			2,0			
			,6			
Column Total		75	49	30	6	160
		46,9	30,6	18,8	3,8	100,0

DUALROLE by ISOLAT11 in that setting how socially isolated

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	ISOLAT11 not at a l isolat 1	mildly i solated 2	moderate ly isola 3	extremel y isolat 4	Row Total
0		15 50,0 20,0 9,4	8 26,7 16,3 5,0	6 20,0 20,0 3,8	1 3,3 16,7 ,6	30 18,8
1		11 73,3 14,7 6,9	1 6,7 2,0 ,6	3 20,0 10,0 1,9		15 9,4
2		5 29,4 6,7 3,1	8 47,1 16,3 5,0	4 23,5 13,3 2,5		17 10,6
3		11 50,0 14,7 6,9	6 27,3 12,2 3,8	4 18,2 13,3 2,5	1 4,5 16,7 ,6	22 13,8
4		20 51,3 26,7 12,5	12 30,8 24,5 7,5	6 15,4 20,0 3,8	1 2,6 16,7 ,6	39 24,4
5		8 47,1 10,7 5,0	6 35,3 12,2 3,8	1 5,9 3,3 ,6	2 11,8 33,3 1,3	17 10,6
6		3 30,0 4,0 1,9	4 40,0 8,2 2,5	3 30,0 10,0 1,9		10 6,3
7		2 25,0 2,7 1,3	2 25,0 4,1 1,3	3 37,5 10,0 1,9	1 12,5 16,7 ,6	8 5,0
(Continued)	Column Total	75 46,9	49 30,6	30 18,8	6 3,8	160 100,0

DUALROLE by ISOLAT11 in that setting how socially isolated

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	ISOLAT11 not at all isolated 1	mildly isolated 2	moderately isolated 3	extremely isolated 4	Row Total
10			1 100,0 2,0 ,6			1 ,6
12			1 100,0 2,0 ,6			1 ,6
Column Total		75 46,9	49 30,6	30 18,8	6 3,8	160 100,0

SOCCAT by ISOLAT11 in that setting how socially isolated

SOCCAT	ISOLAT11 not at all isolated 1	mildly isolated 2	moderately isola 3	extremely isolat 4	Row Total
1,00	51 50,0 69,9 33,1	31 30,4 67,4 20,1	17 16,7 58,6 11,0	3 2,9 50,0 1,9	102 66,2
2,00	22 43,1 30,1 14,3	14 27,5 30,4 9,1	12 23,5 41,4 7,8	3 5,9 50,0 1,9	51 33,1
4,00		1 100,0 2,2 ,6			1 ,6
Column Total	73 47,4	46 29,9	29 18,8	6 3,9	154 100,0

Count
Row Pct
Col Pct
Tot Pct

PRTOTCAT by ISOLAT11 in that setting how socially isolated

PRTOTCAT	ISOLAT11 not at all isolated 1	mildly isolated 2	moderately isola 3	extremely isolat 4	Row Total
1,00	46 48,4 63,0 29,9	28 29,5 60,9 18,2	18 18,9 62,1 11,7	3 3,2 50,0 1,9	95 61,7
2,00	26 47,3 35,6 16,9	16 29,1 34,8 10,4	10 18,2 34,5 6,5	3 5,5 50,0 1,9	55 35,7
3,00	1 33,3 1,4 ,6	1 33,3 2,2 ,6	1 33,3 3,4 ,6		3 1,9
4,00		1 100,0 2,2 ,6			1 ,6
Column Total	73 47,4	46 29,9	29 18,8	6 3,9	154 100,0

Count
Row Pct
Col Pct
Tot Pct

INCIDCAT by RESIDE12 reside while working at primary clinic s

INCIDCAT	RESIDE12			
Count / Row Pct / Col Pct / Tot Pct	same small town 1	within the same 2	two different co 3	Row Total
1,00	28 26,2 70,0 17,8	54 50,5 67,5 34,4	25 23,4 67,6 15,9	107 68,2
2,00	12 24,0 30,0 7,6	26 52,0 32,5 16,6	12 24,0 32,4 7,6	50 31,8
Column Total	40 25,5	80 51,0	37 23,6	157 100,0

FINCAT by RESIDE12 reside while working at primary clinic s

FINCAT	RESIDE12			
Count / Row Pct / Col Pct / Tot Pct	same small town 1	within the same 2	two different co 3	Row Total
1,00	35 25,0 87,5 22,3	74 52,9 92,5 47,1	31 22,1 83,8 19,7	140 89,2
2,00	4 25,0 10,0 2,5	6 37,5 7,5 3,8	6 37,5 16,2 3,8	16 10,2
3,00	1 100,0 2,5 ,6			1 ,6
Column Total	40 25,5	80 51,0	37 23,6	157 100,0

DUALROLE by RESIDE12 reside while working at primary clinic s

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	RESIDE12 same small town 1	within the same 2	two different co 3	Row Total
0		8	17	6	31
		25,8	54,8	19,4	19,7
		20,0	21,3	16,2	
		5,1	10,8	3,8	
1		5	6	3	14
		35,7	42,9	21,4	8,9
		12,5	7,5	8,1	
		3,2	3,8	1,9	
2		1	13	3	17
		5,9	76,5	17,6	10,8
		2,5	16,3	8,1	
		,6	8,3	1,9	
3		7	9	4	20
		35,0	45,0	20,0	12,7
		17,5	11,3	10,8	
		4,5	5,7	2,5	
4		7	18	14	39
		17,9	46,2	35,9	24,8
		17,5	22,5	37,8	
		4,5	11,5	8,9	
5		2	9	5	16
		12,5	56,3	31,3	10,2
		5,0	11,3	13,5	
		1,3	5,7	3,2	
6		3	5	1	9
		33,3	55,6	11,1	5,7
		7,5	6,3	2,7	
		1,9	3,2	,6	
7		4	3	1	8
		50,0	37,5	12,5	5,1
		10,0	3,8	2,7	
		2,5	1,9	,6	
	Column Total	40	80	37	157
		25,5	51,0	23,6	100,0

(Continued)

DUALROLE by RESIDE12 reside while working at primary clinic s

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	RESIDE12 same small town 1	RESIDE12 within the same 2	RESIDE12 two different co 3	Row Total
8		1 100,0 2,5 ,6			1 ,6
10		1 100,0 2,5 ,6			1 ,6
12		1 100,0 2,5 ,6			1 ,6
Column Total		40 25,5	80 51,0	37 23,6	157 100,0

SOCCAT by RESIDE12 reside while working at primary clinic s

Page 1 of 1

SOCCAT	RESIDE12 same small town 1	within the same 2	two different co 3	Row Total
1,00	22 21,8 59,5 14,6	53 52,5 68,8 35,1	26 25,7 70,3 17,2	101 66,9
2,00	14 28,6 37,8 9,3	24 49,0 31,2 15,9	11 22,4 29,7 7,3	49 32,5
4,00	1 100,0 2,7 ,7			1 ,7
Column Total	37 24,5	77 51,0	37 24,5	151 100,0

PRTOTCAT by RESIDE12 reside while working at primary clinic s

Page 1 of 1

PRTOTCAT	RESIDE12 same small town 1	within the same 2	two different co 3	Row Total
1,00	26 27,7 70,3 17,2	49 52,1 63,6 32,5	19 20,2 51,4 12,6	94 62,3
2,00	8 15,1 21,6 5,3	27 50,9 35,1 17,9	18 34,0 48,6 11,9	53 35,1
3,00	2 66,7 5,4 1,3	1 33,3 1,3 ,7		3 2,0
4,00	1 100,0 2,7 ,7			1 ,7
Column Total	37 24,5	77 51,0	37 24,5	151 100,0

INCIDCAT by ENCOUN13 unintentionally encounter current/former

INCIDCAT	Count / Row Pct / Col Pct / Tot Pct	ENCOUN13 everyday (0)	once per week (1)	once per month (2)	once per year (3)	(4)	Row Total
1,00		1 ,9 100,0 ,6	10 9,2 43,5 6,2	25 22,9 50,0 15,5	35 32,1 83,3 21,7	26 23,9 81,3 16,1	109 67,7
2,00			13 25,0 56,5 8,1	25 48,1 50,0 15,5	7 13,5 16,7 4,3	6 11,5 18,8 3,7	52 32,3
(Continued)	Column Total	1 ,6	23 14,3	50 31,1	42 26,1	32 19,9	161 100,0

INCIDCAT by ENCOUN13 unintentionally encounter current/former

INCIDCAT	Count / Row Pct / Col Pct / Tot Pct	ENCOUN13 never (5)	Row Total
1,00		12 11,0 92,3 7,5	109 67,7
2,00		1 1,9 7,7 ,6	52 32,3
	Column Total	13 8,1	161 100,0

FINCAT by ENCOUN13 unintentionally encounter current/former

FINCAT	Count / Row Pct / Col Pct / Tot Pct	ENCOUN13 0	everyday 1	once per week 2	once per month 3	once per year 4	Row Total
1,00		1 ,7 100,0 ,6	16 11,2 69,6 9,9	45 31,5 90,0 28,0	39 27,3 92,9 24,2	30 21,0 93,8 18,6	143 88,8
2,00			6 35,3 26,1 3,7	5 29,4 10,0 3,1	3 17,6 7,1 1,9	2 11,8 6,3 1,2	17 10,6
3,00			1 100,0 4,3 ,6				1 ,6
Column Total		1 ,6	23 14,3	50 31,1	42 26,1	32 19,9	161 100,0

(Continued)

FINCAT by ENCOUN13 unintentionally encounter current/former

FINCAT	Count / Row Pct / Col Pct / Tot Pct	ENCOUN13 never 5	Row Total
1,00		12 8,4 92,3 7,5	143 88,8
2,00		1 5,9 7,7 ,6	17 10,6
3,00			1 ,6
Column Total		13 8,1	161 100,0

DUALROLE by ENCOUN13 unintentionally encounter current/former

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	ENCOUN13 0	1 everyday	2 once per week	3 once per month	4 once per year	Row Total
0			2 6,5 8,7 1,2	3 9,7 6,0 1,9	12 38,7 28,6 7,5	11 35,5 34,4 6,8	31 19,3
1			2 13,3 8,7 1,2	4 26,7 8,0 2,5	2 13,3 4,8 1,2	5 33,3 15,6 3,1	15 9,3
2			1 5,9 4,3 ,6	6 35,3 12,0 3,7	6 35,3 14,3 3,7	2 11,8 6,3 1,2	17 10,6
3			1 4,5 4,3 ,6	6 27,3 12,0 3,7	9 40,9 21,4 5,6	4 18,2 12,5 2,5	22 13,7
4		1 2,6 100,0 ,6	4 10,5 17,4 2,5	14 36,8 28,0 8,7	9 23,7 21,4 5,6	7 18,4 21,9 4,3	38 23,6
5			4 23,5 17,4 2,5	8 47,1 16,0 5,0	2 11,8 4,8 1,2	2 11,8 6,3 1,2	17 10,6
6			2 20,0 8,7 1,2	5 50,0 10,0 3,1	2 20,0 4,8 1,2	1 10,0 3,1 ,6	10 6,2
7			5 62,5 21,7 3,1	3 37,5 6,0 1,9			8 5,0
(Continued)	Column Total	1 ,6	23 14,3	50 31,1	42 26,1	32 19,9	161 100,0

DUALROLE by ENCOUN13 unintentionally encounter current/former

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	ENCOUN13 never 5	Row Total
	0	3 9,7 23,1 1,9	31 19,3
	1	2 13,3 15,4 1,2	15 9,3
	2	2 11,8 15,4 1,2	17 10,6
	3	2 9,1 15,4 1,2	22 13,7
	4	3 7,9 23,1 1,9	38 23,6
	5	1 5,9 7,7 ,6	17 10,6
	6		10 6,2
	7		8 5,0
(Continued)	Column Total	13 8,1	161 100,0

DUALROLE by ENCOUN13 unintentionally encounter current/former

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	ENCOUN13 0 everyday	1 once per week	2 once per month	3 once per year	4	Row Total
8			1 100,0 4,3 ,6				1 ,6
10				1 100,0 2,0 ,6			1 ,6
12			1 100,0 4,3 ,6				1 ,6
Column Total		1 ,6	23 14,3	50 31,1	42 26,1	32 19,9	161 100,0

(Continued)

DUALROLE by ENCOUN13 unintentionally encounter current/former

DUALROLE	Count / Row Pct / Col Pct / Tot Pct	ENCOUN13 5 never	Row Total
8			1 ,6
10			1 ,6
12			1 ,6
Column Total		13 8,1	161 100,0

SOCCAT by ENCOUN13 unintentionally encounter current/former

SOCCAT	Count / Row Pct / Col Pct / Tot Pct	ENCOUN13 0 everyday	1 once per week	2 once per month	3 once per year	4	Row Total
1,00		1 1,0 100,0 ,6	9 8,7 40,9 5,8	28 26,9 58,3 18,1	27 26,0 69,2 17,4	27 26,0 84,4 17,4	104 67,1
2,00			12 24,0 54,5 7,7	20 40,0 41,7 12,9	12 24,0 30,8 7,7	5 10,0 15,6 3,2	50 32,3
4,00			1 100,0 4,5 ,6				1 ,6
Column Total		1 ,6	22 14,2	48 31,0	39 25,2	32 20,6	155 100,0

(Continued)

SOCCAT by ENCOUN13 unintentionally encounter current/former

SOCCAT	Count / Row Pct / Col Pct / Tot Pct	ENCOUN13 5 never	Row Total
1,00		12 11,5 92,3 7,7	104 67,1
2,00		1 2,0 7,7 ,6	50 32,3
4,00			1 ,6
Column Total		13 8,4	155 100,0

PRTOTCAT by ENCOUN13 unintentionally encounter current/former

PRTOTCAT	Count / Row Pct / Col Pct / Tot Pct	ENCOUN13 everyday (0)	once per week (1)	once per month (2)	once per year (3)	(4)	Row Total
1,00		1 1,0 100,0 ,6	7 7,2 31,8 4,5	23 23,7 47,9 14,8	29 29,9 74,4 18,7	27 27,8 84,4 17,4	97 62,6
2,00			12 22,2 54,5 7,7	24 44,4 50,0 15,5	10 18,5 25,6 6,5	5 9,3 15,6 3,2	54 34,8
3,00			2 66,7 9,1 1,3	1 33,3 2,1 ,6			3 1,9
4,00			1 100,0 4,5 ,6				1 ,6
(Continued)	Column Total	1 ,6	22 14,2	48 31,0	39 25,2	32 20,6	155 100,0

PRTOTCAT by ENCOUN13 unintentionally encounter current/former

PRTOTCAT	Count / Row Pct / Col Pct / Tot Pct	ENCOUN13 never (5)	Row Total
1,00		10 10,3 76,9 6,5	97 62,6
2,00		3 5,6 23,1 1,9	54 34,8
3,00			3 1,9
4,00			1 ,6
	Column Total	13 8,4	155 100,0