THE EXPERIENCES OF MENTAL HEALTH NURSES WHOSE CLIENTS DISCLOSE SEXUAL CONTACT WITH A FORMER PHYSICIAN: THREE COMPARATIVE CASE STUDIES

By

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ABSTRACT

This study explored the subjective experiences of community mental health nurses whose clients disclosed sexual contact with a former physician. Theory, opinion literature, and my own clinical experience support the belief that disclosures such as these challenge nurses with their complexity and intensity. Three nurses' accounts of their clients' disclosures constituted cases for comparison and generated a beginning theoretical framework. Data were collected by multiple, indepth, unstructured, audiotaped interviews. Open coding and axial coding techniques of content analysis were used to analyze the data collected, and each set of data was then compared and contrasted.

The Cycle of Focusing Attention was identified as the integrating concept in a conceptual framework that describes how nurses alternately focus their attention on the client and on themselves, with the goal of alleviating client suffering. Contained in this cycle were: two concepts, Focusing on the Client and Focusing on Self; four sub-concepts, Collecting Information, Using Interventions, Experiencing Feelings, and Analyzing Thoughts; and two modifying-concepts, Analyzing Boundaries and Analyzing Power.

Data analysis revealed that despite the passage of time the details and circumstances of the disclosure experience remained vivid in the nurses' minds. Nurses experienced moral outrage and powerlessness at the physicians' misuse of
professional power, and these feelings did not lessen with time. Despite their personal feelings the nurses maintained a professional demeanor and consistently treated their clients in caring and respectful ways. The nurses were immediately certain that the physician's sexual behavior was unethical. They understood the therapeutic needs of their clients related to client-therapist sexual contact, and the social and ethical demands of reporting.

Implementation of the study's findings could lead to more effective clinical practice, thereby lessening the suffering of both client and nurse.
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Figure 1. Conceptual Framework:

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This thesis came about through the combined efforts of many people. My idea for this thesis originated from observing my colleague and fellow traveller, David Conlin, struggle to make meaning of his client's disclosure of sexual contact with a physician. "Alice", "Cathy", and "Lynne" answered questions about their disclosure experiences, and in so doing, re-experienced their struggles. I am grateful to them for that. Clarissa Green and Jinny Hayes, with their larger vision, encouraged, directed, and supported both the process of research and of academic writing. More importantly, Clarissa, Jinny, and Janet Ericksen offered me empathy and reassurance thus providing me with comfort throughout this difficult challenge. Linda Davidson learned how to do open coding, and then spent many hours co-analyzing my data. Alison Beaumont critically read innumerable drafts, and gently and humorously offered invaluable literary suggestions. In the early morning Joan Ferguson read countless drafts before yoga.

I want to acknowledge Sherre Friberg, who for health reasons, was unable to accompany me on my last academic writing journey. I thank and acknowledge my treasured friends who, with understanding and graciousness, allowed me to disappear from our relationships and write this thesis. Finally, I am deeply touched by my dad, Tom Mimee, who listened, and gave me his total, loving support.

Thank-you, all.
CHAPTER ONE: Making the Disclosure of Client-Therapist Sex Visible

Background and Significance of the Problem

The very serious problem of client-therapist sexual contact is demanding our attention more and more frequently, either because it is occurring more often or because it is being reported more conscientiously (Gartrell, Herman, Olarte, Feldstein, & Localio, 1986). Typically, disclosure involves the abused person (usually a woman) discussing the problem with her/his current health professional. Learning that a previous therapist has had sexual contact with her/his client presents a number of issues for the second professional (Brown, 1990; Galletly, 1993; Kiely and Kiely, 1987; Strasburger, Jorgenson, and Randles, 1990). Many professionals have found that they themselves are made to appear unethical when they report the abuse to the suitable professional bodies (Stone, 1984; cited in Penfold, 1992). Similarly, a significant number of abused clients are reported to have experienced harassment, repeated challenges to their credibility, and humiliating interrogations about their past sexual relationships, when they have notified professional organizations or ethics committees of their abuse (Penfold, 1992). For the abused client this response constitutes further abuse (Stone, 1984; cited in Penfold, 1992), and the current health professional must respond to a second crisis (Galletly, 1993). It is known that many of these health professionals do not report client-therapist
sexual abuse (Gartrell et al., 1987). While reasons for this are suggested in the literature (Gartrell et al., 1987; Galletly, 1993; Penfold, 1992), the cognitive processes leading to the current health professionals' decisions have not been studied. This research report describes and analyzes the experiences of three female community mental health nurses whose clients disclosed sexual contact with a previous physician.

Sexual contact of any kind between a health care professional and a client is unethical. According to Black's Law Dictionary, medical and mental health professionals are in a "fiduciary relationship where there is special confidence reposed in the one who in equity and good conscience is bound to act in good faith and with due regard to the interests of one reposing the confidence" (Black, 1979, p. 753). The Committee on Physician Sexual Misconduct [CPSM] (1992) states that sexual contact between a physician and a patient is always unethical. 'Exploitation', the use of someone for one's own selfish purposes, is the essence of patient-physician sexual contact (CPSM, 1992). The Canadian Medical Association (CMA) Code of Ethics Annotated for Psychiatrists (1980) addresses the nature of the patient-psychiatrist relationship, stating that the ethical psychiatrist will scrupulously avoid using this relationship to gratify his or her own emotional, financial, and sexual needs.
A physician offering medical or mental health services is in a fiduciary relationship. This is a special relationship in which the physician accepts the trust and confidence of the patient to act in the latter's best interest (Feldman-Summers, 1989). Physicians occupy a position of power and trust and they betray that trust when they sexualize the relationship (CMA, 1980; CPSM, 1992; Penfold, 1992; Rutter, 1991). This is especially true of psychotherapeutic relationships where clients are encouraged to suspend their usual defences and reveal private thoughts and feelings (Canadian Psychiatric Association [CPA], 1989). As well, clients are actively encouraged to develop strong feelings toward the therapist which are manifestations of transference, that is, a repetition of attitudes and feelings experienced in earlier important relationships (Blackshaw & Patterson, 1992; Rutter, 1991).

Clients are harmed when they have sexual contact with their physicians or mental health professionals (Brown, 1990; Williams, 1992). In a survey seeking information from psychologists about their patients who had been sexually involved with a previous therapist, the psychologists reported that 90% of these patients had suffered severe ill effects including depression, emotional disturbance, impaired social adjustment, suicidal feelings and behavior, and increased use of drugs and alcohol. Eleven percent were hospitalized, and 1% had committed suicide (Bouhoutsos, Holroyd, & Lerman, 1983; cited in Galletly, 1993). Pope and
Bouhoutsos (1986) describe a Therapist-Patient Abuse Syndrome closely resembling a Post Traumatic Stress Syndrome, which includes the following symptoms: ambivalence, guilt, feelings of isolation, feelings of emptiness, cognitive dysfunction, identity and boundary disturbance, inability to trust, sexual confusion, lability of mood, suppressed rage, and increased suicidal risk. These symptoms have been well documented by other mental health professionals (Blackshaw & Patterson, 1992; Penfold, 1992; CPSM, 1992; Rutter, 1991; Searight & Campbell, 1993).

Abused clients report feelings of hurt, loneliness, abandonment, fear, and guilt (CPSM, 1992). As well, research indicates that a significant number of these abused clients have been sexually abused as children or adults, and are therefore not only revictimized by sexual contact in therapy (Rutter, 1991), but also feel ashamed and self-blaming, and attempt to protect the abuser by concealing the relationship (Galletly, 1993).

Despite codes of ethics and literature alerting mental health professionals to its destructiveness, sexual exploitation of clients continues to occur. A 1986 national survey of American psychiatrists revealed that 7.1% of male and 3.1% of female psychiatrists acknowledged sexual contact with their clients (Gartrell et al.). Another national American survey by Gartrell et al. (1987) found that 65% of 1432 respondents reported treating patients who had had sexual contact with previous therapists. A 1986 survey of
American psychologists in private practice indicated 9.4% of males and 2.5% of females acknowledged sexual contact with their clients (Pope, Keith-Speigel, & Tabachnick). In 1992, Gartrell, Milliken, Goodson, Thiemann, and Lo surveyed 10,000 American family practitioners, internists, obstetrician-gynecologists, and surgeons to determine the current prevalence of physician-patient sexual contact. Nine percent of 1,891 respondents acknowledged sexual contact with one or more patients. In a British Columbian physician survey, 3.8% of males and 2.3% of females reported sexual contact with their clients (CPSM, 1992). Clearly, clients being sexualized by their therapists is a significant problem.

Increasing public and professional outcry, books written by victims of physician sexual contact, and pressure from consumer groups have alerted clients to the prevalence, destructiveness and immorality of client-therapist sexual contact. As clients are informed of the issues and the source of the problem is clearly identified as the physician, it is possible that more and more clients may feel sufficiently encouraged and supported to reveal past sexual contact to their present therapist.

A mental health professional, such as a mental health nurse, informed by a client of sexual contact with a previous physician or psychiatrist, faces a complex problem (Galletly, 1993). According to Galletly (1993), the problem presents as a conflict of rights which include: (a) the
patient has the right not to be sexually exploited, and to
do nothing may confirm a perception of themselves as a
powerless victim; (b) the patient has the right to effective
treatment and the sexual contact severely jeopardizes
ongoing psychotherapy; (c) the patient has the right to
confidentiality and breaking confidentiality may be
experienced as a further disregard for his or her needs by
the psychiatric profession; (d) other patients of this
psychiatrist have the right not to be sexually exploited;
(e) the accused psychiatrist has the right to answer
allegations; (f) the profession has the duty to maintain
ethical standards; and (g) the community has the right to
expect ethical conduct from those entrusted with the care of
the mentally ill.

Health professionals, including mental health nurses,
when learning about client-therapist sexual contact, are
presented with this complex and difficult problem. How three
nurses resolved this difficulty was the focus of my
research.

Inductive analysis requires that the researcher's
assumptions about the phenomenon be stated and then
suspended (Oiler, 1986). The researcher may then be able to
fully understand the experience of the individual and not
impose an a priori hypothesis on the experience (Oiler,
1986). Heidegger (cited in Packer & Addison, 1989) argues:

That in order to know anything at all, we must have
some pre-understanding of what is knowable. This pre-
understanding, or fore-structure, remains largely in
the background as taken-for-granted. However, when the object of investigation is human activity, it is important to recognize the influence of our forestructure in order to arrive at a more explicit interpretation or account. (p. 52)

My clinical mental health practice shapes my preunderstanding of the nurses' disclosure experience. The primary focus of my clinical practice is working with adult clients who were sexually abused as children. As a nurse-therapist, I am aware not only of the immense psychological damage that is done to these people at the time, but also of the long lasting and debilitating effects of sexual abuse. Hearing a disclosure is always difficult, and I must always seek ways of resolving my emotional and cognitive reactions. How clients and therapists in fact resolve difficult psychological issues is a passionate interest of mine. Hence, when a social worker colleague described his psychological struggle following a client's disclosure of client-therapist sexual contact, I found myself exceedingly intrigued. The incident sparked my curiosity, and I wondered if female mental health nurses would have similar struggles when their clients disclosed sexual contact with their physician.

I have worked in mental health for twenty-nine years, and I understand the struggles of mental health nurses. I believe that most nurses not only care about their clients, but also are deeply troubled by clients' abuse disclosures.

The culture of the mental health teams affected my preunderstanding of the nurses' disclosure experience.
Clients are cared for by primary workers who can be a Registered Nurse (RN), Registered Psychiatric Nurse (RPN), Social Worker, Psychologist, or Occupational Therapist. Occasionally other backgrounds are represented on these multi-disciplinary teams as well. Despite the differences in educational background or training everyone has the same job description and does the identical job (however, only the nurses can give injectable medications). The educational and licensing differences between the RNs and RPNs are not operational on the job, and they are both referred to as mental health nurses.

In addition, the literature influenced my preunderstanding of the nurses' disclosure experiences of the phenomenon of client-therapist sexual contact; I had reviewed some of the literature about the incidence and prevalence of this phenomenon and learned that reporting the abuse was an issue. As well, I reviewed specifically mental health nurses' disclosure experiences, seeking some indication of other significant issues imbedded in this phenomenon of client-therapist sex.

My most important preunderstanding is that I believe that client-therapist sex is always wrong; it is absolutely unethical. There is no ethical dilemma about therapist-client sexual contact among nurses who have a good understanding of what an ethical dilemma is (Davis, 1981). Davis used questionnaires to determine how 205 randomly selected nurses understood the concept of an ethical dilemma
and how they defined an ethical dilemma in their practice. Fifty-two percent of respondents had a good grasp of this concept. Diploma nurses described the clinical issues involved in their dilemma more often than degree nurses. Diploma nurses disagreed more often with physicians on ethical issues than did degree nurses. Younger nurses had more ethical dilemmas with patients, families, physicians and institutions than older nurses.

Determining the frequency with which nurses encountered specific ethical issues and how disturbed they were by these issues was the focus of an exploratory study designed by Berger, Seversen, and Chvatal (1991), and part of my preunderstanding. They used a random stratified proportional sample drawn from four surgical units, three medical units, three intensive care units, and nursing administration in a 250-bed hospital. Questionnaires were sent to 104 nurses, with a 50% return rate. The findings showed that, overall, nurses encountered few ethical issues and that their level of disturbance increased as the number of ethical issues increased. This study did not support the findings reported in other literature which suggested a recent increase in ethical dilemmas. Nurses reported that they rarely encountered professional ethical issues such as substance abuse, illegal activity, or patient abuse. The researchers claimed that the issue of underreporting or failure to recognize an ethical issue cannot be overlooked, and have recommended more study in this area.
Major mental health professional organizations, including those of nursing, have codes of ethics directing them to report unethical behavior. However, it is not always reported, and this was another of my preunderstandings. Child abuse, like client-therapist sex, is unethical behavior, but unlike the latter, professionals are required by law to report. Kalichman, Craig, and Follingstad (1988) investigated the tendency of mental health professionals to report child abuse. A sample consisted of 101 clinicians working within three community health centers in Florida. The subjects' professions included Bachelor's level mental health technicians (39%), Master's level therapists (41%), Registered Nurses (10%), Ph.D. Clinical Psychologists (7%), and Medical Doctor Psychiatrists (3%). Each subject completed an experimentally controlled vignette with three systematically manipulated factors. The factors included victim age, type of abuse, and victim reactions during an interview. The subjects were randomly assigned to a vignette situation. Results indicated 81% of the clinicians tended to report the presented case of child abuse. The clinician's tendency to report depended on the certainty they had that the abuse was occurring. The victim's behavior during the interview seemed to affect reporting through its impact on the clinician's conviction that the abuse was happening. The more educated professionals reported more frequently.

Another of my preunderstandings about the frequency of reporting unethical behavior includes a study by Gartrell,
et al. (1987). These researchers investigated the reporting practices of psychiatrists who knew of sexual misconduct by colleagues. Surveys were sent to 5574 randomly-selected American psychiatrists. The response rate was 26%. Six point four percent (n = 84) of the respondents acknowledged sexual contacts with a total of 144 patients. Sixty-five percent (n = 920) of respondents reported treating patients who had been sexually involved with a previous therapist. Non-offenders were the least likely, and repeat offenders most likely, to have treated such patients. Eighty-seven percent of the respondents who had treated these patients assessed the previous sexual contact as always harmful to their patients; 6.4% assessed the contact as sometimes helpful; 0.8% assessed the contact as helpful in all cases. Thirty-nine percent (n = 536) of the respondents knew psychiatrists who had been sexually involved, and only 6% of these 536 respondents filed complaints. Eight percent of respondents who had treated previously abused patients filed a report with a professional association. The majority of respondents (56%) favored mandatory reporting of therapist-patient sexual contact. Although the response rate of the survey was moderate (26%) and raises concerns about generalizability, the 6.4% overall prevalence of therapist patient sexual contact found in this survey is consistent with the prevalence rate in other surveys.

A factor that affects therapists' decisions to report is the stress that reporting may cause the client. My
concern about that stress was part of my preunderstanding as well. In the opinion of Strasburger, Jorgenson, and Randles (1990), the therapist's dilemma when the reporting of sexually exploitative psychotherapists is made mandatory. Mental health professionals unanimously agree that therapist-patient sexual contact is unethical. When therapists decide to report, they must consider the negative effects of the reporting, not only upon the patient (possible revictimization), but also upon the patient's relationship with the treating therapist (possible distrust due to a loss of confidentiality). Reporting is a crucial issue because a substantial proportion of exploitive therapists abuse multiple victims (Gartrel et al., 1987). If unreported, these perpetrators can be expected to victimize unsuspecting future patients. Gartrel and his colleagues claim that three American states have adopted mandatory reporting statutes; their approaches vary from educating survivors of sexual exploitation to requiring the patient's consent to report.

Another of my preunderstandings was that often there are negative consequences for nurses who report unethical behavior. In their article of opinion, Kiely and Kiely (1987) describe the consequences of disclosing for nurses who felt ethically bound to act in the interest of the patient rather than of their employer. Nurses found that they had no legal recourse if they were subsequently dismissed. Although, on the one hand, most professional
associations now require nurses to report behavior that endangers client welfare, on the other hand, they have not always supported disclosing the incompetent practice of a fellow health team member (CNA, 1984; cited in Kiely and Kiely, 1987). In addition, hospital management may use suppressive techniques such as dismissal, black-listing, or threats of physical violence as a response to "whistleblowing" (Westin, 1981; cited in Kiely and Kiely, 1987). Peers and colleagues may isolate and shun the nurse who discloses. The decision to disclose has serious ramifications for both the individual making the decision and the other involved parties.

Everyone has a psychological response to an ethical issue and this, too, was part of my preunderstanding. I usually respond with feelings of indignation, and I think about helping the victim and punishing the offender. In an article of opinion, Brown (1990) describes how unethical behavior affects the offender's colleagues personally, professionally, and socially. She contends that although feminist therapists have championed confronting unethical, abusive and sexually exploitive practices by male therapists, feminist therapists have collectively denied and reframed the existence of sexual exploitation of women by women. Colleagues of the offending therapist feel wounded and betrayed, and suffer a loss of trust. Brown describes confrontation strategies, and suggests a process of
mediation for the problematic feminist therapy colleague and the client.

To summarize my preunderstandings, the literature indicates that client-therapist sexual contact is either a growing problem or it is being reported more often. Disclosure is frequently made to other health professionals, including mental health nurses. It is apparent that disclosure presents the second professional with a difficult and complex problem that must be resolved. Prior to being able to resolve this problem, the phenomenon must be better understood. Research literature shows that professionals can identify ethical dilemmas. When therapists believe a client's disclosure, they tend to report the offending therapist. However, the possibility of reporting often confronts therapists with the necessity of weighing the consequences of protecting future clients from abuse against threatening the therapeutic relationship they currently have with their client. When nurses expose unethical behavior, management may dismiss, blacklist or physically assault them. As well, they may be shunned by their colleagues.

Hence, I thought a study which compares and contrasts mental health nurses' experiences would provide a detailed, though preliminary, description of the disclosure experience. Once this phenomenon is clearly described, and the issues and conflicts are identified, other nurses in this situation may be encouraged to be reflective and
analytical. The purpose of this study was to show how three mental health nurses made meaning of this phenomenon.

**Research Question**

The research question for this study was: What is the nature of the experience of a mental health nurse when a client discloses sexual contact with a former physician?

**Conceptual Definitions**

The following conceptual definitions informed the research:

1. **Sexual contact**: any overt or covert sexual behaviors between a male physician and his female or male patient.

2. **Mental health nurse**: a female RN or RPN who counsels clients with mental health concerns. Male RNs or RPNs were not included in order to make the study as homogeneous as possible.

3. **Former physician**: a male medical doctor who has had a treatment relationship with a female or male patient for psychiatric reasons. Again female doctors have been excluded in an attempt to limit the variation in the phenomenon.

**Introduction to the Method**

Both the case study method and content analysis were chosen as methodological approaches for this research. The case study method has provided the basis from which most social science knowledge has been developed (Kazdin & Tuma, 1982; Runyan, 1982; Sterling & McAlley, 1992; Younger, 1985). A case study is an intensive investigation into and systematic presentation of information about the background,
current status, and environmental interactions of a single unit: an individual, a group, an organization, or a society (Yin, 1984; Kazdin & Tuma, 1982; Runyan, 1982; Polit & Hungler, 1991).

The case study method may be used to generate hypotheses which may be tested by other research, to address research questions in which the variables and interconnections have not been identified, and to understand the subjective experience of an individual. The case study method may also be used when there is little control over events, when the time frame is restricted, or when a large sample is not available (Kazdin & Tuma, 1982; Holm, 1983; Meier & Pugh, 1986; Sterling & McNalley, 1992). Nursing has not systematically used the case study method to generate knowledge (Holm, 1983; Meier & Pugh, 1986; Sterling & McNalley, 1992; Younger, 1985); however, the strategy is recommended for improving client care (Kazdin & Tuma, 1982; Meier & Pugh, 1986; Sterling & McNalley, 1992).

Cases are flexible and systematic enough to be open to any methods appropriate for collecting and analyzing data (Kazdin & Tuma, 1982; Runyan, 1980; Yin, 1989). When a question is discovered during the course of collecting and analyzing data, a qualitative methodology is appropriately used to systematically guide further inquiry.

Qualitative methods are used to uncover, describe, and understand what lies within any phenomenon about which little is known (Miles & Huberman, 1994; Strauss & Corbin,
Since little is known about the nurses' experiences when a client discloses sexual contact with a physician, comparing case studies, using a qualitative method, seemed an appropriate approach to beginning understanding of the phenomenon.

In qualitative research, the data are in the form of words (Miles & Huberman, 1994), and interviews and observation are the most common methods of data collection (Strauss & Corbin, 1990). In this study, indepth, unstructured interviews were used to collect data. Data collection takes place concurrently with data analysis (Miles & Huberman, 1994; Strauss & Corbin, 1990). Data analysis directs the focus for further data collection (Miles & Huberman, 1994). Comparative content analysis directed data collection and analysis for this study (Glaser & Strauss, 1967; Strauss & Corbin, 1990).

**Limitations**

The findings of comparative case studies are not generalizable to a population; they are generalizable to an existing or new theory (Miles & Huberman, 1994). This study explored only the experiences of three female mental health nurses who work in a community mental health setting. It did not address the experiences of other nurses in other settings, nor those with other professional bases, who would have their own unique experiences. As well, the experiences of male nurses was not addressed, and neither the clients' nor the former therapists' reactions were investigated.
Finally, both the wide variation of time between disclosures and the interviews, and the different contexts in which the disclosures took place, preclude an optimum indepth understanding of disclosure experience, though they do provide breadth.

In summary, this study has been designed to explore three mental health nurses' disclosure experiences. Little is known of how mental health nurses make meaning of this difficult and complex experience. In Chapter One I have described the background and the significance of the research problem, revealed my preunderstandings, introduced the methodology, and identified the limitations of this research. In Chapter Two I will describe the research method in more depth. Following that, in Chapter Three I will present and discuss the findings, and, in Chapter Four, I will summarize my findings, state my conclusions, suggest the study's implications, and make recommendations for nursing practice, research, education, and administration.
CHAPTER TWO

METHOD

A qualitative case study approach was chosen to study three mental health nurses' experience of clients' disclosure of client-therapist sexual contact. In this chapter, I describe the procedures I used to select participants, collect data, protect human rights, and establish methodological rigor.

A case study is an intensive investigation and systematic presentation of information about the background, current status, and environmental interactions of a single unit: an individual, a group, an organization, or a society (Yin, 1989; Kazdin & Tuma, 1982; Runyan, 1982; Polit & Hungler, 1991). A case study method may be used: (a) to understand the subjective experience of an individual, (b) to generate hypotheses which may be tested by other research, (c) to address research questions in which the variables and interconnections have not been identified, (d) when there is little control over events, (e) when the time frame is restricted, (f) when a large sample is not available, and/or (g) to improve client care (Holm, 1983; Kazdin & Tuma, 1982; Meier & Pugh, 1986; Sterling & McNalley, 1992; Younger, 1985).

Given the circumstances associated with my study, the case study method was suitable because: the research question addressed the subjective experience of an individual, there was little control over disclosure events,
there was a restricted time frame, and a large sample was not available. Case studies are flexible and systematic enough to accommodate any appropriate means of collecting and analyzing data (Kazdin & Tuma, 1982; Runyan, 1982; Yin, 1989). Qualitative methods were indicated since they are used to uncover, describe, and understand phenomena about which little is known (Miles & Huberman, 1994), and for this study, content analysis was selected. Data were collected using multiple, indepth, unstructured interviews, and analyzed using open coding and axial coding techniques (Strauss & Corbin, 1990). The entities as whole units (Yin, 1989) were then compared and contrasted with each other.

**Selection of Participants**

The purpose of a qualitative case study approach is to understand the subjective experience of an individual (Kazdin & Tuma, 1982). In case study method each individual is considered a unit, a whole entity (Yin, 1989). Participants who have actually had the experience under study are selected. For this study, I selected three female mental health nurses who had experienced a client disclose sexual contact with a former therapist. Characteristics of the three nurses are described more fully in the next chapter.

**Selection Criteria**

Selection criteria were established to ensure as much homogeneity as possible. The sampling criteria for participants were: a female nurse who had mental health
experience, who worked on a mental health team, who had experienced the disclosure experience, and who was willing to participate in one or two hour-long interviews. For this study, the offending therapist was required to be a male physician who had had a counselling relationship and had abused the client. There were no restrictions about the client.

Recruitment Procedures

I polled colleagues and acquaintances about possible disclosure experiences, explaining the purpose of my study to them, and inviting them to participate. I also asked four mental health team directors to read a memo to their teams requesting volunteers for my study. In this memo I both explained the purpose of my research and asked for volunteers. To anyone telephoning and making an inquiry, I described the interview procedures, time expectations, and how I would protect both their and the offenders' confidentiality. Of the six nurses who volunteered, three participated, one dropped out because she thought that recounting her disclosure experiences would be too painful, and another because she moved from the city. The remaining nurse was not chosen because the offending therapist was a priest, rather than a medical doctor.

Data Collection

In qualitative research, interviews and observations are the most common methods of data collection (Strauss & Corbin, 1990). In this study, the research question provided
the initial focus for data collection. Data were collected by indepth, unstructured interviews, which are typically used when there is no preconceived idea of the content. The aim of the researcher using unstructured interviews is to wholly understand the participant's experience and to refrain from influencing the participant (Polit & Hungler, 1991).

During the initial interview, I reviewed the purpose of the study and reminded each participant that she could withdraw from the study at any time. Each participant read and signed the consent (see Appendix B, p. 102), and none asked for additional information although questions were encouraged. Since qualitative research is "an ongoing, dynamic, changing process, [wherein] unforeseeable events and consequences [arise], researchers need to facilitate negotiation and renegotiation to protect our collaborators' human rights" (Munhall, 1988, p. 151). At the second interview, I not only reviewed the purpose of the study, but also asked again for and received permission to interview. In addition, because participants are at risk for some psychological discomfort as they talk about their experiences (Ramos, 1989), I asked the study nurses about their reactions to the previous interview. The study nurses were aware that I would, with their permission, make arrangements for them to receive prompt therapeutic intervention if necessary, and if mutually agreed on.
Neither the participants nor I found it necessary to implement this plan.

Before beginning the interview, I engaged the participant in small "talk" and used humor to create a relaxed atmosphere for both of us. Each interview was approximately one hour long and took place at either the participant's or my office. Each of these offices was private and quiet, and had comfortable chairs arranged at right angles, facilitating the sharing of thoughts and feelings. Although I made attempts to increase our comfort, I found the research style of interviewing (asking questions for the researcher's benefit) uncomfortable and difficult, since it is contrary to my therapeutic style of interviewing (asking questions for the client's benefit).

Initially, a broad statement relating to the study nurses' disclosure experience was used (see Appendix A, p. 101), then subsequently only prompting comments were used to clarify and expand their explanations. I followed this process until the participants indicated that they had no more to say about their disclosure experience, and I felt satisfied that I really understood their experience. The audiotaped interviews were subsequently transcribed verbatim by a professional typist. Transcripts were returned to me within two or three days. I made copies of these transcriptions, and delivered them to my reviewer who had been selected for her theoretical sensitivity to the studied phenomenon. The reviewer's task was to provide an
independent coding of the interview narratives (Hinds, Scandrett-Hibden, & McAulay, 1990).

Data analysis, focusing the direction for data collection, takes place concurrently with data collection (Miles & Huberman, 1994; Strauss & Corbin, 1990). After analyzing the initial data from each of the three interview transcripts, I had a preliminary understanding of the study nurses' experiences. However, I recognized that I did not have a complete understanding about specific elements. As well, since the study nurses talked about different issues I wanted to confirm that they had not forgotten anything relevant. So I arranged a second interview to validate, refute, and expand my understandings. Again, I asked open ended questions or made prompting comments that would deepen my understanding of their experiences. Second interviews occurred within six weeks of the first for two of the participants. The third participant could not be reinterviewed because she was out of town for a prolonged period.

Field notes added more data. After each interview I wrote down my reactions to the content and the process of the interview, my thoughts or hunches I may have had about the participant, and my observations about their body language, posture, and speech patterns. I also noted my thoughts and feelings as I analyzed data, and I jotted down parts of discussions that I had with the reviewer who was validating my analysis and use of coding descriptors. These
notes were scribbled down on 3 X 4 pieces of paper, one idea to a paper, and kept in a file folder marked "notes to me". These notes helped me focus so that I could synthesize and understand the data, as well as keep a check on my values and assumptions. After analyzing the first set of data, I made notes which I took into all subsequent interviews, reminding me to ask those questions typical of a researcher rather than those of a therapist (Polit & Hungler, 1991).

**Data Analysis**

The process of analyzing the data took place concurrently with data collection. To illustrate the technical approaches, the following briefly describes my process with one nurse's data set:

Following transcription, comparative content analysis was used to analyze the data. Content analysis is a procedure for analyzing verbal communications in a systematic and objective fashion (Miles & Huberman, 1994). I began by reading the complete transcript to refresh my memory of the interview. Then I carefully read each phrase and/or sentence, and searched for a concept word that would capture its meaning. Initially I had great difficulty arriving at concept words which would accurately describe the idea embedded in the phrases, clauses, sentences, and sections. Once selected I wrote the concept word beside the phrase on the transcript, and on a stickie-note I wrote the word, page, and participant's number, and I attached it to the corresponding place in the transcript. Methodically, I
worked my way through the transcript. I experienced a welcome familiarity when I recognized a previously discussed phenomenon or idea. A previously chosen concept word or descriptor was then noted. Strauss & Corbin (1990) call this explosion of the data into conceptual parts open coding.

After I had written numerous concept words on the transcript and stickie-notes, I consulted my reviewer to assess my consistency in sorting. This check of consistency provides information on the repeatability of my observations (Hinds, Scandrett-Hibden, & McAulay, 1990). Then I read through the transcript, simultaneously removing the stickie-notes and creating groups which contained similar meaning concepts. This grouping process is called categorizing, and the phenomenon represented by a category is more abstract than the concepts grouped under it (Strauss & Corbin, 1990). For example, employing open coding I conceptualized some data as "expanding client's story", "exploring client's experience," "asking direct questions", and "asking for facts." I grouped these concepts together and called the category "questioning." This category was grouped with others and named "interventions". As I examined the categories, I tried to understand the theme they were revealing, or were part of.

Each of the study nurse's interviews was analyzed using the same method. Eventually I realized the data were revealing a story about the study nurse's experience of paying attention to either herself or the client. Subsequent
to this, I reinterviewed two of the study nurses to clarify data and broaden the description of the concepts and categories, and affirmed or refuted my interpretations.

I continued to examine the data "looking at configurations, associations, causes, and effects within the case--and only then [I turned] to comparative analysis of a (usually limited) number of cases" (Ragin, 1978; cited in Miles & Huberman, 1994). I looked for similarities and differences among the study nurses’ experiences, and when appropriate I used the same concept and category names. By examining and comparing the concepts and categories across the three case studies, I established more abstract and integrating concepts (Strauss & Corbin, 1990). For example, the category of "interventions" was grouped under a primary concept which I eventually called Focusing on the Client.

**Ethical Considerations**

Prior to beginning the study, I obtained approval from the University of British Columbia Behavioral Sciences Screening Committee for Research and Other Studies Involving Human Subjects. Then I polled the mental health teams searching for nurses willing to participate in the study.

I ensured confidentially by the following measures: (a) I used an identification number, rather than a name, on the transcript and on the tape; (b) audiotapes and transcripts were locked in my filing cabinet when not being used; (c) audiotapes and transcripts will be destroyed a year after the study is completed; (d) only two members of my thesis
committee, the reviewer, and myself had access to the coded information; and, (e) by prearranged agreement, the name of the offender and the agency were not mentioned by the participants. This last precaution was verbally noted at the beginning of every interview. Lastly, the nurses' names were disguised to ensure their confidentiality.

**Criteria for Rigor**

Case studies have traditionally been criticized for lack of rigor and poor generalizability (Meier & Pugh, 1986; Runyan, 1982; Yin, 1989; Younger, 1985). Yin (1989) suggests several tactics that can ensure rigor once the data are collected and analyzed. Since these tactics are not appropriate for qualitative research where data collection and analysis are done simultaneously, the criteria for establishing rigor in interpretive studies were used instead.

Qualitative studies include four methods for establishing rigor: credibility, fittingness, auditability and confirmability (Guba & Lincoln, 1981; cited in Sandelowski 1986). "A qualitative study is credible when it represents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own" (Sandelowski, 1986, p. 30). In this study, credibility was achieved by thoroughly checking the data gathered to determine if it made sense when it was compared with other data collected. An uninvolved mental
health therapist-colleague independently coded the data. As well, interpretations of the data were taken back to two of the participants for verification of intent. Finally, a representative selection of typical data were included in the report of the findings.

"When the findings of the study 'fit' into the contexts outside the study situation and when its audience views its findings as meaningful and applicable in terms of their own experience" (Guba & Lincoln, 1981; cited in Sandelowski, 1986, p. 32), then fittingness, the second criterion, is achieved. Fittingness is the truth value of the data. In this study fittingness was achieved by my giving a true representation of the data presented, by an independent coding of the data, and by receiving a validating "a-ha" from another nurse when I tell her about my findings.

Auditability is another criterion for measuring reliability, and is achieved when all decisions involved in transforming data into theoretical statements are reported (Burns, 1989). A study is auditable when another researcher can clearly follow the decision-making trail of the researcher in the study, and come to comparable conclusions (Sandelowski, 1986). To achieve this in this study, I clearly described the data collection process and completely recorded all data. I gave sufficient raw data to illustrate my conceptual decisions, and provided definitions explaining my rationale for the development of concepts and sub-concepts. Notes describing my continually evolving
theoretical decisions have been kept. Finally, concepts, sub-concepts, and categories were continually compared with raw data to ensure the link between the theoretical statements and data was clear (Burns, 1989).

Confirmability is the final criterion for establishing rigor in qualitative research, and refers to the neutrality or unbiasedness of the data (Sandelowski, 1986). This criterion is met when auditability, fittingness, and credibility have been suitably established.

Also of concern is the reciprocal effect that the investigator and the participant have on each other (Lamb & Huttlinger, 1989). In qualitative research the investigator makes explicit personal assumptions and preconceptions at the onset of the research, and then suspends them during the inquiry process (Lamb & Huttlinger, 1989). However, during the inquiry, the investigator's personal views are affected by the participant's understanding of their experience (Anderson, 1991). These reciprocal influences are continuous; therefore, I constantly monitored my values, beliefs, and interests. Not only did I try to understand their influence on the study, but I also integrated this understanding into the study's findings (Marcus & Fischer, 1989; cited in Lamb & Huttlinger, 1989).

Summary

The case study method, in this instance a comparison of three in-depth cases of nurses' disclosure experiences, produces a promising initial analysis of the nurses'
process. In this study, three mental health nurses were selected, and then participated in multiple, in-depth, unstructured interviews. Open coding and axial coding techniques were used to analyze the data collected, and each case study's data were then compared and contrasted with each other. The result was an informative and rich picture of these nurses' struggle to make meaning of the complex and difficult problem of client disclosure. This struggle is described and discussed in the next chapter.
CHAPTER THREE
FINDINGS AND DISCUSSION

This research was composed of three case studies. In this chapter, a synopsis of each disclosure case provides context for the concepts that the three contain. Each case study is introduced through a description of the nurse's experience and skills, the context and setting of the disclosure, and the nurse's specific single disclosure experience. Concepts emerging from the study nurses' descriptions are organized into a conceptual framework which I use to present the findings. Relevant literature is used to elaborate and discuss specific findings.

The case studies are presented using fictitious names and in the chronological order of the clients' disclosures of their abuse experiences: the disclosure to Cathy occurred 15 years before I interviewed her, the disclosure to Lynne occurred five years prior, and the disclosure to Alice occurred one and a half years before. The participants were initially interviewed within one month of each other. The terms client and patient are used interchangeably as are the terms participant, nurse therapist, and study nurse.

Case Studies

Cathy's Disclosure Account

Cathy is a registered nurse, with approximately nine years experience in psychiatric acute care nursing and psychiatric outpatient care. When the disclosure experience happened, 15 years ago, Cathy was in her first year of
community mental health nursing. Her client disclosed sexual contact with a former psychiatrist.

The mental health team where Cathy worked is mandated to provide psychiatric care for patients with serious mental illnesses, and its goal is to prevent the need for future psychiatric hospitalizations. At the time of disclosure, there were seven such mental health teams in the city where the study took place. Each team was composed of health care workers who could be registered nurses, registered psychiatric nurses, social workers, occupational therapists, or psychologists. Each health care worker was directly responsible for her/his patient's care. In addition, the teams engaged psychiatrists who were responsible for assessing, diagnosing, prescribing medication for the patients, and for providing consultation for the primary workers. As a primary worker, Cathy would offer to work with specific patients and she would choose a consulting psychiatrist to assist her with each one. Cathy would see the client alone or accompanied by the consulting psychiatrist, depending on the needs of the client. As well, she would determine the frequency of the interviews.

The client who disclosed her abuse experience to Cathy was a young divorced woman. Cathy had worked with her during a psychiatric hospitalization, and she knew that the client had both a psychotic illness and a substance abuse problem. In therapy, Cathy was constantly intervening in the client's acting out behavior (taking minor drug overdoses, attempting
suicide, demanding extra appointments, being verbally abusive, and refusing to comply with treatment requests) and/or in the client's psychotic and delusional thinking. Cathy saw this client either weekly for supportive counselling, or several times a week for crisis management.

In counselling sessions, over a period of several months, the client talked to Cathy about her association with a former psychiatrist. She told Cathy that she was "in love", that "this was the best relationship" she had ever had, and that it was a sexual relationship. Since Cathy knew the client had psychotic episodes, she thought she had to make sure that this was not an association connected with the client's fantasy life. After exploring the situation carefully, Cathy determined that the client had and was continuing to have a sexual liaison with her former psychiatrist.

Cathy felt "concerned" and "frustrated in an angry way" when she realized that there was a sexual liaison, and she immediately discussed this situation with the consulting psychiatrist. She believed the liaison was harmful to the client, and although she did not know specifically what action to take, she knew that she wanted the liaison to end.

Lynne's Disclosure Account

Lynne is an experienced registered psychiatric nurse. She has worked in psychiatric acute care hospital settings, and in both emergency and mental health team community settings. At the time of the disclosure Lynne had been
working in the community for 13 years, at a mental health team different from Cathy's but part of the same health service, and therefore exhibiting the same structure, organization, clients, and method of delivering service.

Further, Lynne had a private psychotherapy practice. She had had extensive training in working with survivors of sexual abuse, and she had undertaken intensive psychotherapy training. Although Lynne had the experience of disclosure while working with a private practice client, she was simultaneously working on a community mental health team, a factor common to all three nurses in this study.

The disclosure happened five years before this study's data collection. Lynne had been seeing this client for a month, for one hour a week. At the time, the client was in crisis; she was talking about ritual sexual abuse, sexual abuse, suicide, and shame. She told Lynne of the many therapists to whom she had disclosed her abuse history, and described how fearful she had felt when none of these therapists believed her. In trying to understand her client's experience more fully, Lynne asked "have you ever been abused by a therapist"? The client disclosed that two years before, her psychiatrist at the time had threatened to commit her to a local psychiatric hospital if she did not have sex with him on a weekly basis. Believing that she had no choice, the client had acquiesced.

Lynne immediately felt "furious". At the time, she noted the feeling and temporarily put it away, with the
resolve that she would talk to a therapist friend about it later. Also, she had the thought "this is no surprise to me, because I've heard about this guy before", and felt appalled that "he was still doing it."

Lynne then directed her attention toward her client, and her exploration provided her with more details about the situation. She informed her client "what that person did was not OK; it was very unethical". She asked her if she wanted to do anything about it, and the client refused. Lynne accepted and understood her refusal. Since this incident had happened two years before, neither she nor the client believed it should take priority over the fact that the client was actively suicidal. Lynne proceed to attend to her client's safety and other therapy issues.

Alice's Disclosure Account

Alice's disclosure experience was the most recent. It occurred one and a half years before our interview, and approximately two years after she had started work at a community mental health team. At the time of disclosure Alice had considerable experience as a registered psychiatric nurse. Prior to joining the team, she had worked in a psychiatric acute care hospital unit and a psychiatric day program; as well she had taught mental health nursing in a Registered Psychiatric Nurses' Program, at a community college.

Her disclosure experience took place in the mental health team setting. Since it was the same mental health
team as Lynne's, and similar to Cathy's, the setting bore similar characteristics described above. An essential part of care that a client receives at all the mental health teams is an initial assessment. This assessment is comprised of data submitted by the referring person (intake data), and a comprehensive psychiatric interview. Both the consulting psychiatrist and the primary worker are involved in the latter, and it is normally done when they interview a client for the first time.

Alice and the consulting psychiatrist were in the midst of the client's initial assessment when the disclosure experience occurred. Alice had read on the intake data that the male client had a long psychiatric history with the following diagnoses: borderline personality disorder, sociopathic traits, and substance abuse. As well, a sexual relationship with a former psychiatrist was reported. As part of their initial assessment, the consulting psychiatrist and Alice asked the client many questions. Suddenly, Alice reported "the client insinuated that there was a current sexual relationship between him and his general practitioner." He made this disclosure "voluntarily, spontaneously, and in the middle of talking about another topic." Without alluding to the alleged relationship with the previous psychiatrist mentioned in the intake data, Alice confirmed with the client that he was talking about a relationship with his current general practitioner.
Alice immediately felt appalled that this "situation could happen." She recalls thinking "this is serious" and feeling an urgency to do something about it, though she chose not to show her feelings or to make any comment. Both Alice and the consulting psychiatrist mentally noted the disclosure, and finished the initial assessment. They arranged for a subsequent appointment with the client.

These three disclosure cases, though they occurred over a wide span of time, offered an opportunity to explore the nature of the disclosure experience for nurse therapists. The accounts of the three events and the nurses' description of their responses to them reveal a single, cyclical process that can be explained in terms of several concepts.

**Conceptual Framework: Overview**

This section presents the findings of the study nurses' disclosure experiences. The findings are presented concurrently to minimize repetition. Initially, I shall describe my general conceptualization of this phenomenon, and subsequently discuss and elaborate three concepts in detail, illustrating them with quotations from the data. The concepts of this construction are capitalized; concepts selected for discussion are underlined.

The nurses' disclosure experiences are conceptualized as a process called The Cycle of Focusing Attention. This primary concept, Focusing Attention, integrates two main concepts which emerged from the data: **Focusing on the Client** and **Focusing on Self**. Both of these further separate into
sub-concepts and modifying-concepts. The diagram (see Figure 1, p. 40) illustrates the integrating concept, the concepts, sub-concepts, and modifying-concepts, the cognitive and behavioral process of a nurse concentrating her attention on either her client or herself. It is a complex, cyclical mental and behavioral process with parts that are not mutually exclusive; in fact, I see them as highly integrated and interdependent. For the purposes of this discussion, however, they are described as separate and discrete parts.

Focusing Attention emerged as the essential and integrating concept of all three nurses' disclosure experiences. Focusing Attention involves the nurse's cognitive and behavioral process of concentrating her attention on either her client or herself. It is a complex, cyclical mental and behavioral process with the goal of alleviating client suffering. In this process, the nurse alternately Focuses Attention on her client and on herself. When the nurse focuses on the client, focuses on herself, and then refocuses on the client, this may be called the Cycle of Focusing Attention.

The essential aspect of the nurse's disclosure experience, the Cycle of Focusing Attention, is the nurse in relation to her client. This relationship is comprised of two main concepts: Focusing on the Client and Focusing on Self.
Figure 1.
Cycle of Focusing Attention (Primary Concept)

Focusing on the Client (Concept) Focusing on Self (Concept)

*Collecting Information (Sub-concept) *Analyzing Thoughts (Sub-concept)

*Analyzing Boundaries
*Analyzing Power (Modifying-concepts)

*Using Interventions (Sub-concept) *Experiencing Feelings (Sub-concept)

When the nurse is Focusing on the Client, she listens to and observes her client's behavior. When she is Focusing on Self, she turns inward and processes the information she has received while listening to and observing the client's behavior, and she notices her personal reactions (feelings or thoughts) to it. Then, based on the results of her mental processing, the nurse returns to Focusing on the Client and makes a verbal or behavioral intervention. This begins another cycle.

Focusing on the Client is comprised of two sub-concepts, Collecting Information and Using Interventions. When the nurse is Collecting Information, she listens to the client and she observes her/his behavior. Using
Interventions involves what the nurse said and how she acted towards her client.

Focusing on Self, the other concept of Focusing Attention, is comprised of two sub-concepts: Experiencing Feelings and Analyzing Thoughts. When the nurse is Analyzing Thoughts she is considering conceptually the issues that her client may be experiencing. Two modifying-concepts that further describe Analyzing Thoughts include Analyzing Boundaries and Analyzing Power. When the nurse is Analyzing Boundaries, she thinks about crossed therapy boundaries which allowed client-therapist sex to occur; when Analyzing Power, she thinks about the power differential that allowed the client abuse. When the nurse is Experiencing Feelings, she recalls her emotional responses to her client's words and/or behaviors.

I conceptualize the study nurses' disclosure experiences as the Cycle of Focusing Attention. The Cycle consists of: two concepts, Focusing on the Client and Focusing on Self; four sub-concepts, Collecting Information, Using Interventions, Experiencing Feelings, and Analyzing Thoughts; and two modifying-concepts, Analyzing Boundaries and Analyzing Power. In this Cycle, the nurse's attention alternates between Focusing on the Client and Focusing on Self.

**Explication of the Cycle of Focusing Attention**

This sub section takes the conceptualization just outlined and expands it.
Focusing on the Client

Focusing on the Client is a concept in the Cycle of Focusing Attention. Focusing on the Client refers to the nurses' cognitive and behavioral processes of concentrating attention on their clients' thoughts, feelings, and behaviors. As clients described their thoughts, feelings, and behaviors, the nurses focused their attention on their clients and became involved in Collecting Information. Collecting Information is the cognitive process of compiling data about their client by listening to the client, and observing the client's behavior. Through this ongoing process, the nurses attempted to understand their clients' problems and to facilitate their clients' recovery by a verbal, non-verbal, or behavioral response. For example, Lynne reported listening sensitively and respectfully, and she recalled watching her client closely for signs of distress. She actively tried to understand her client's experience. Lynne recalled that both she and her client had similar understandings about the problem and the therapy goal. She talked about this mutual understanding like this:

We were working on issues related to her sexual and ritual abuse.... When I asked her if she wanted to report him [the psychiatrist] she said "no", and I totally understood. We carried on dealing with other issues that were more pressing at the time.... She was suicidal at the time.

Like Lynne, when Cathy was Collecting Information she reported that her goal was to understand her client's experience. Unlike Lynne, who had the same understanding of
the problem as her client, Cathy and her client had different understandings of the problem. Cathy recalled thinking her client's problem was that she was having a sexual liaison with a former psychiatrist, whereas the client thought that her problem was that she was not having enough sexual meetings with him. As part of the process of Collecting Information, Cathy remembered listening to and observing behavior designed to maneuver her (Cathy) into facilitating the sexual liaisons.

We spent session after session with her wanting me to help make phone calls or figure out how she could meet him at his apartment or office. He was like a magnet for her.... I couldn't change her mind or get her to work on anything else.

Cathy also recalled listening to her client not only verbally abusing and threatening her, but also unrealistically praising her and asking her forgiveness. When the offending psychiatrist restricted their sexual meetings, Cathy recalled observing her client's acting out behavior which included prescription and non-prescription drug overdoses, increased family conflict, and threats of suicide and homicide.

Alice's experience of Collecting Information, in her specific disclosure account, was different from both Lynne's and Cathy's. Unlike Lynne who reported that she and her client had a similar understanding of the problem and therapy goal, and unlike Cathy who recalled understanding the problem differently than her client, Alice reported that she felt she never understood what her client thought his
problem was. "I just didn't know what he wanted ... his agenda kept changing.... I just never knew ... his facts kept changing." She reported listening to her client's insinuations that he was currently having a sexual relationship with his physician. She recalled that at various times he would threaten to set himself on fire in front of her; on several occasions he dragged himself into her office in a semi-comatose state due to lithium overdoses and/or alcohol intoxication.

After Collecting Information and mentally processing it, the study nurses then used the data to guide their interventions. Using Interventions, a sub-concept of Focusing on the Client, is a process that all three nurses recall using. This concept captures the verbal, non-verbal, or behavioral responses of the nurse, directed towards the client, with the intention of fostering the client's recovery. Alice remembered that her interventions were verbal and behavioral. She recalled exploring her client's implication that he and his general practitioner were having a sexual relationship. After using interventions to understand his meaning, she remembered explaining to him that this sexual relationship was abusive, which she recalled was not his perception. Alice saw herself as supportive, understanding, consistent, clear, and empowering, and when the client became at risk for harming himself, she recalled immediately intervening and preparing
for hospitalization on either a voluntary or involuntary basis.

Like Alice, when Cathy spoke about Using Interventions she remembered using both verbal and non-verbal behaviors. She remembered asking questions to determine her client's reality. "I wanted to know if this sexual relationship was real or part of her psychosis.... It was real; they were having a sexual relationship." She recalled how she unsuccessfully attempted to set limits with her client, and to show the client the connection between her acting out behavior (threats of committing suicide, taking medication overdoses, and abusing alcohol), and her sexual involvement with the psychiatrist. Cathy reported acting quickly to have her client assessed for medications, and admitted to a crisis hostel or a hospital. At times, when necessary, she would have her committed to hospital.

Different from both Alice's and Cathy's experiences of Using Interventions, Lynne reported using only verbal interventions. She remembered intervening with questions which expanded her client's story and/or explored her beliefs and feelings. She reported using interventions which not only defined the psychiatrist's behavior as abusive and wrong, but also supported and validated her client's experience as abusive. She attempted to empower her client by asking for direction on whether or not to report the offender, and by accepting and supporting her client's negative decision.
Focusing on the Client is the first aspect of the Cycle of Focusing Attention, the process used by the nurses to respond to abuse disclosures, and has been used to present part of the findings. The second part of the Cycle, Focusing on Self, with its sub-concepts Experiencing Feelings and Analyzing Thoughts, and modifying-concepts Analyzing Boundaries and Analyzing Power, is a parallel part of the process of Focusing on the Client. In the following section selected concepts from this aspect of the Cycle of Focusing Attention are elaborated and discussed in the context of the relevant literature. These selected concepts are underlined to facilitate their identification.

Focusing on Self

The major concept, Focusing on Self, is an integral part of the nurses' disclosure experience. As well as Focusing on their Clients, Collecting Information, and Using Interventions the nurses looked inward, and, in Focusing on Self, searched for their own reactions to the information. These included both cognitive processing and identifying feelings.

Analyzing Thoughts was part of each nurse-therapist's disclosure experience, and occurred when the nurses reflected upon their analytical thoughts. Analyzing Thoughts is the mental process of thinking about the issues embedded in therapy. This process allowed them access to a theoretical framework which enhanced their understanding of the problem, and alerted them to the therapy issues that
their clients would most likely experience. This knowledge guided their interventions and focused their thinking. For example, Lynne remembered thinking about the notions of boundaries, power, and breaking trust, and recalls being aware that she would need to be cognizant of these issues. (The underlined concepts are elaborated upon and discussed in detail).

Alice remembered thinking about the notions of boundaries, and because they were blurred, her client was able to misinterpret his physician's behaviors and words. Taking time to try to determine the truthfulness of her client's disclosure was a significant part of her experience. She remembered thinking about the issues of breaking trust and power.

Cathy had difficulty remembering her thoughts since her disclosure experience happened 15 years before. She reported that since then, her thoughts about sexual abuse had changed considerably. She remembered thinking that the offending psychiatrist was without boundaries and she wondered if there was ever an acceptable time for clients and therapists to get involved sexually. She remembered thinking about how psychiatrists had the power to manipulate the therapy relationship, and to coerce others into not reporting them.

Another part of the disclosure experience and of Focusing on Self occurred as the nurses listened to their clients' abuse stories. Each of these nurses reported experiencing intense feelings. Experiencing Feelings is
noticing and naming an internal physical sensation. Lynne recalled Experiencing Feelings of being "outraged", "horrified", "appalled", and "furious." She remembered feeling "powerless" and "outraged" about the reporting system. When working with her client, she recalled feeling "caring" and feeling "concerned" about her.

"Powerless", "impotent", "helpless", and "angry" were the feeling words Cathy used when she remembered both the disclosure experience and her attempts to stop the sexual encounters. At times she said that she would dread seeing her client because the client would "take everything out of me." She remembered feeling "concern" for her since her client was frequently either threatening suicide or actively suicidal. She reported feeling "frustrated" with the offending psychiatrist who she believed was manipulating her client. Fifteen years later, Cathy expressed her caring this way: "At times I think about her and wonder how she's doing."

Alice, also, talked about the feelings she experienced. She remembered she was "appalled" and "surprised" at the possibility of a sexual relationship, and she recalls that she felt an "urgency" to intervene. She remembered feeling "powerless" and "really frustrated" that the client kept changing his treatment goals and his disclosure story. He was frequently in crisis and at those times she felt "concern", "stressed", and "hurried".
In summary, as I described and compared the study nurses' accounts of their responses to their clients' disclosure of sexual contact by a previous therapist, nine elements emerged for me. These nine elements (see Figure 1. page 40) I conceptualized as follows: the primary integrating concept is the Cycle of Focusing Attention; the two working concepts are Focusing on the Client and Focusing of Self; subsumed under Focusing on the Client are two sub-concepts, Collecting Information and Using Interventions; subsumed under Focusing on Self are two sub-concepts, Experiencing Feelings and Analyzing Thoughts; two modifying-concepts of Analyzing Thoughts are Analyzing Boundaries and Analyzing Power.

The literature strongly supports the notion that boundaries and power are crucial dynamics in situations of client-therapist sexual contact (Gutheil, 1989; Herman, 1992; Gutheil and Gabbard, 1993). Further, although therapists debate the relative importance of the relationship between client and therapist, this report asserts that the relationship between the study nurses and their clients was a fundamental factor in the nurses' experience of client disclosure.

These three concepts (boundaries, power, and the client-therapist relationship) are considered germane to the phenomenon under study, that of client-therapist sexual contact and its disclosure to a subsequent mental health professional. These concepts are therefore singled out for
special attention in this study. The relationship is studied by taking a close look at Focusing on the Client in the context of traditional writings on the therapeutic relationship. Later, Analyzing Boundaries and Analyzing Power are also discussed with reference to the relevant literature.

Discussion of Focusing on the Client

Focusing on the Client was pivotal to each nurse's disclosure experience. It refers to the nurse's cognitive and behavioral process of concentrating attention on her client's thoughts, feelings, and behaviors. It is an essential element of the therapeutic relationship; without Focusing on the Client there can be no therapy. As a therapist, the nurse enters into a special relationship in which she accepts the trust and confidence of her client to act in the latter's best interest (Feldman-Summers, 1989). Although the study nurses did not use this exact term, the literature typically calls this a therapeutic relationship. Hence, I turn briefly to the therapeutic relationship literature to better understand the participants' disclosure experience and the concept of Focusing on the Client.

The therapeutic relationship has long been considered an essential part of the psychological therapy process. Although psychotherapists believe that therapy cannot be done without such a relationship, they do not agree with each other about its importance. Since it was first
articulated by Freud (Kahn, 1991), in the late 1890s, there has been much controversy about its importance and dynamics. An historical perspective is helpful in understanding the controversial issues, and in explaining what the nurses reported.

The notion was coined by Freud who was trained to believe that what mattered most was what the physician did to, and for, the patient's condition; the relationship between the patient and physician was irrelevant. In the late 1890s, however, as he observed a colleague treat a woman with hysteria, he began observing what was happening between the two. Freud determined that this relationship, which he called the therapeutic relationship, was much deeper and more complex than the conventional patient physician relationship.

Freud became convinced that in psychoanalysis the relationship between patient and physician (analyst) was crucial, that it was invariably intense, mysterious, and very complex regardless of how it may appear on the surface (Kahn, 1991; Parloff, 1986). His way of being with patients was active and engaging. He carried on a real dialogue with patients and tended to their current needs. He intuitively knew when to engage and when to be distant. However, instead of advocating that other analysts follow his behavior, he encouraged them to be distant (Kahn, 1991).

What the study nurses described as Focusing on the Client resembles Freud's style of being with his clients. A
100 years after Freud, these nurses described their experiences as being actively involved in listening, observing, and intervening. They behaved differently from Freud's fellow analysts who were distant, remote, and silent. These analysts waited for the transference to "appear" and spoke only when offering an interpretation about the patient's transference. Transference, Freud believed, was the main point of psychotherapy, and it refers to the patients transferring their attitudes, feelings, fears, and wishes from long ago onto their analysts (Kahn, 1991; Jacobson, 1993). It is beyond the scope of this thesis to describe the dynamics of this complex process of transference; simply put, the analysts' therapy goals were to provide maximum illumination of transference manifestations, to protect client autonomy, and to protect client's vulnerability to exploitation (Jacobson, 1993).

Freud's followers had goals for therapy, and the study nurses reported goals when Focusing on the Client. However, encouraging the transference was not one of them; when Focusing on the Client, their goals were to help their clients and to protect them from harm.

In the 1940s, an American analyst, Carl Rogers, was a major force in initiating a change which humanized the perceptions about psychotherapy (Kahn, 1991). He believed that the therapeutic attitude required empathy and unconditional regard for clients, and genuineness on the part of the therapist. Rogers (1961) directed therapists to
demonstrate an attitude of uncompromising respect for the client and to refrain from imposing their interpretations onto their clients. Different from analysts, whose therapeutic attitude was distant and silent, the study nurses' attitudes were respectful and caring, closer to the Rogerian view.

The radical political climate of the 1960s demanded a democratic therapeutic relationship. Therapists searched for ways to make the clinical relationship more egalitarian. This groundswell led to the encounter movement which emphasized authenticity and symmetry (Kahn, 1991). Authenticity meant that the therapist should be as honest and as emotionally exposed as the client, and symmetry demanded that the therapist be willing to do anything that the client was asked to do. Encounter therapists spontaneously and openly revealed whatever feelings or thoughts were evoked, and often used unrestrained confrontation. They intentionally shared their feelings of hostility, boredom, excitement, or sexual attraction with their clients (Kahn, 1991).

The study nurses were different from the radical therapists described previously. Not only did they contain their own feelings, but they adamantly asserted that it was wrong for therapists to act out their feelings by engaging in sex with their clients. Alice stated: "I was appalled that it might even be a sexual relationship." Cathy declared: "It was so wrong, he really took advantage of her."
She was so vulnerable. He was wrong to have a sexual relationship with her." Lynne expressed her beliefs strongly: "Sex between a therapist and a client, a physician and a client, is totally taboo, it's totally wrong, it's a massive abuse of power.... It's a violation of trust!"

Although Rogers (1961) was actively involved in, and influenced by, the encounter movement, his notions of authenticity and of positive regard were taken to extremes by some members of this movement. Some of these therapists practiced in a harshly confrontational manner, and believed they had permission to give clients physical, loving, and sexual support (Kahn, 1991). Rogers, however, practicing in a less aggressive manner, believed he should provide only emotional support.

When the study nurses were Focusing on the Client they offered emotional support, as Rogers' would have within the context of the therapeutic relationship. But, unlike him, they gave more. When their clients were behaving in harmful and destructive ways (such as threatening suicide or taking drug overdoses) the nurses recalled that they had arranged voluntary and involuntary hospital admissions or emergency doctor appointments. They were working with clients who had severe personality disorders and who were low-functioning, unlike the high-functioning patients typically seen by analysts. And unlike the encounter movement therapists, who in their therapeutic relationships sometimes exploited and harmed their clients (Kahn, 1991), the transcripts reveal
these nurses as having been warm, empathic, helpful, and caring.

The debate continues today among therapists about the importance of the therapeutic relationship. For example, the therapeutic relationship is deemed indispensable in psychodynamic therapies including the following: psychoanalytic therapy, object relations therapy, Gestalt therapy, psychosocial therapy, and various body-oriented therapies (Kahn, 1991). Although therapists employing cognitive therapy, behavior therapy, and advice-giving therapy do not actively use the relationship to facilitate patients' changes, they do agree that a positive relationship promotes a positive outcome (Lambert, 1982).

Similar to psychodynamic therapists, the study participants believed that Focusing on the Client was an essential part of their therapy work. They used the relationship as a setting where their clients could both talk about and recover from past and present emotional difficulties. In Focusing on the Client Lynne encouraged her client to talk about some terrifying situations from her past. Lynne reported: "I was listening to her talk about her past sexual abuse and I noticed that she looked scared. I just kept asking her more questions, and she told me about some horrible abuses." Cathy provided this data: by Focusing on the Client, she created an emotional environment where her client revealed suicidal and homicidal thoughts, and she subsequently accepted Cathy's help. Lynne's and Cathy's
interactions and interventions could not have taken place without the process of Focusing on the Client.

Carl Rogers (1961) defined a therapeutic relationship as "a helping relationship in which one of the parties has the intent of promoting the growth, development, maturity, improved functioning, improved coping with life of the other" (p. 39). Implicit in this definition is that a therapeutic relationship has a specific intent and the helper has a unique role. The establishment of a therapeutic relationship depends on certain behaviors of the helper and client which can either foster or hinder a therapeutic relationship. Helper and client's mutual cooperation is essential for a therapeutic relationship.

A therapeutic relationship has a special intent, and in Focusing on the Client, study nurses suggested they had a goal. To me, special intent is the same as a goal. Evaluating and treating initial client problems was the specific intent for establishing a therapeutic relationship and was the goal of these nurses when they were Focusing on the Client. Each nurse provided data about the purpose of her therapeutic relationship. Cathy's goal was to help her client control the "symptoms of her psychotic illness and substance abuse problems," and to provide support during a crisis state in which she was having "terrible arguments with her mother and brother." Alice's goal was to provide safety for her client who was threatening suicide, and "to provide support for difficulties arising from his substance
abuse and personality disorder." When Lynne Focused on the Client, her goal was to help her work through issues related to childhood and adolescent sexual and ritual abuse.

The literature supports the notion that therapeutic relationships are initiated by having specific intent. Barcia and Ruiz (1990) believe the relationship is an interpersonal helping bond intended to help clients meet their needs and attain health. Raising the patient's morale or hope is the intent of most psychotherapies according to Lambert (1982) and Parloff (1986). Promoting patient growth and development, improved functioning, and coping are the intentions purported by Rogers (1961). Finally, Meisler (1991) contends that the patient and therapist come together with the intention of reducing or resolving the patient's problems.

In a therapeutic relationship, the therapist has a specific role, and in Focusing on the Client the study nurses suggested they had a mission or a specific role. They believed they should be available for the benefit of clients, to concentrate on their clients' needs and put these needs ahead of their own. By concealing their feelings when clients disclosed sexual abuse, these study nurses put their clients' needs ahead of their own, and were present to benefit the clients. Lynne gave these data:

Well, I don't let my fury show, because that's wrong, I mean it's not O.K. These are my feelings. She's not here to listen to my feelings, so ... I'll deal with them elsewhere. So I ask her questions about what it was like for her ... I sit on my feelings. Well, I
don't sit on them. I sort of put them away for a while.... But I take some of my anger and I think a whole lot more about her experience and what she wants to do ... and I told her that it's wrong what that person did.

Note how Lynne voiced her own feelings.

Alice described how she put her client's needs ahead of her own in this way. When her client insinuated that he was currently having sexual activity with his general practitioner, Alice said, "I felt surprised, somewhat appalled, but did not share that with the client at the time.... We finished the assessment ... then the session was terminated." She reported that she chose not to show her feelings believing this revelation would have a negative effect on him.

Literature supports Lynne's and Alice's decisions to conceal their feelings as a way of putting their clients' needs first and of Focusing on their Clients. When therapists show their feelings, patients often behave in ways that respond to the therapists' perceived needs. Lambert (1982), in his review of therapist behaviors that contribute to a positive or negative therapeutic relationship, reports that therapist expressiveness has an effect on patients' perceptions and trust. Karon and Vanderbos (1972; cited in Lambert, 1982), tested their hypothesis that "pathogenic" (their quotes) therapists, consciously or unconsciously, use their patients to satisfy their own needs. These therapists were found to be more noxious and less clinically effective than therapists who
put the patients' needs before their own. Patients of the more benign therapists were found to function at higher levels than those of the "pathogenic" therapists.

Alice's disclosure experience illustrates another way of putting the client's needs ahead of her own, that is to say, of Focusing on the Client. In order to put her client's needs first Alice suspended her own reality and believed her client's disclosure, supporting him with encouragement to report the alleged offending physician. Alice described suspending her reality this way: [Although] "the client insinuated that he was currently having a sexual liaison with his general practitioner," Alice had worked with this physician and had a favorable professional relationship with him. As well, she reported:

This doctor had a very good clinical reputation and was highly respected within the mental health community. Whereas [my] client had lied about a lot of things ... he said that he was HIV positive ... and a blood test result we got showed he wasn't.... To me the dilemma is [in believing] someone with a diagnosis of sociopathic traits, borderline personality disorder, and substance abuser. So there is a lot of negative connotations to those diagnoses ... versus someone who has a good reputation.... But no matter how 'flaky' a client is, you need to believe them.

The context of this statement makes Alice's dilemma clear, and believing her client's reports which were contradictory to her personal experience was a dilemma for her.

Like all therapists in therapeutic relationships, these nurses used interventions when Focusing on the Client. Interventions are behaviors that study nurses used to help their clients regain or improve their coping abilities and
prevent further disability (Stuart & Sundeen, 1991). They are for the benefit of the client. These behaviors may be passive, such as listening, or active, such as organizing the signing of committal papers or phoning for an ambulance.

The intervention of careful listening was part of Lynne's disclosure experience and of Focusing on the Client. She reported her experience this way:

[The client] was talking about the number of people, different therapists that she had seen over the years ... about what a frightening experience it had been for her to see so many different people, and nobody really believed her story, which was severe sexual abuse. As well, Lynne recalled that she listened for what the client had not said. She went on: "I asked about who had abused her or if she had ever been abused by a professional ... and she said, 'Yes'.... A psychiatrist who she had been seeing some years ago." Lynne listened to her client so that she could understand and empathize with her. As well, she reported that she validated her client's experience by saying:

What that person did wasn't O.K.; it was very unethical.... I asked her if she wanted to do anything about it.... She didn't want to do any thing about it ... I totally supported that.... She didn't have enough ego strength to go to the College, or go to the police ... I respected her choice.

Literature supports Lynne's intervention of careful listening. The results of a classic study (Truax, Wargo, Frank, Imber, Battle, Nash, & Stone, 1966, cited by Lambert, 1982) showed that patients whose therapists were judged high in levels of accurate empathy, non-possessive warmth or
respect, and genuineness, showed significantly more improvement on overall indices of change than those therapists who were judged low.

Active interventions were part of both Cathy's and Alice's practice with their disclosing clients, and of Focusing on the Client. They reported intervening quickly and decisively when they determined their clients' safety was threatened. They talked about it this way: their clients were angry, anxious, and prone to being in crisis; they frequently threatened suicide, took overdoses of prescribed, over-the-counter, and recreational drugs, and demanded immediate help for personal and social chaos. Cathy and Alice remembered responding immediately and concretely. "I arranged for a hospital bed," "I booked an appointment right then," "I took her to [a crisis facility]", "I took him to detox," "I made emergency appointments to talk or to have her meds adjusted".

The literature reveals that these actions are common and important in psychosocial therapy (Lambert, 1982). They provide the patient with or encourage intellectual understanding of the relationship between feelings and behavior, help reduce anxiety, provide support, and limit acting out behavior. Bandura, Jeffery, and Wright (1974; cited in Lambert, 1982) found in their study that the highest degree of behavior and attitude change was effected in clients who received the most structured interventions.
Therapists exhibit therapeutic qualities in therapeutic relationships, and in Focusing on the Client, study nurses practiced an attitude containing such qualities. Their attitude is a concerned way of being with a client that preserves human dignity, restores humanity, and avoids reducing persons to the moral status of object (Watson, 1988). Each of the study nurses recalled her concern for her client. For example, Cathy was working in a new environment:

I was new and I felt in over my head [referring to her client's suicidal and demanding behavior] ... but I really wanted to help her and I couldn't.... I tried everything I could think of short of locking her up ... to stop her from seeing him.

Cathy felt frustrated with both the client and her own abilities: "I was new at the team and not at all helpful to the client." Summarizing, she described the situation as "impossible", but Cathy kept working with her client and kept wanting to make a difference. Even after the client's discharge, Cathy continued to think about her: "I would wonder how she is doing--O.K. I hope."

Lynne reported her concern when she talked about her client refusing to take action against the offending psychiatrist. She said:

I think it takes a lot of courage to take on the all-powerful medical system. I totally understand her saying no.... She could barely make it through the day ... unable to work ... barely able to care for her kids.... I would never encourage somebody to go and do something if they weren't feeling O.K. about it.

The therapist's qualities have been much studied and reported. Lazarus (1971; cited in Lambert, 1982) in an
uncontrolled study of his patients, found that the most frequently mentioned therapist qualities were sensitivity, gentleness, and honesty. Other qualities included liking the patient, active involvement, inspiring hope and confidence (Frank, 1974; cited in Parloff, 1986); therapeutic warmth or love (Barcia and Ruiz, 1990); caring, empathic, understanding, and interest (Lambert, 1982). Indeed, Rogers (1961) claimed that the qualities of the therapist are more important than therapy techniques.

Essential to establishing a therapeutic relationship is mutual cooperation between the therapist and the client. Either the therapist and/or the client can act in ways which preclude the formation of a therapeutic relationship. In Focusing on the Client, these nurses talked about working together with their clients, that is, mutual cooperation. Working together means behaving in ways congruent with the agreed upon therapeutic goals. Alice reported that when she was Focusing on the Client, she failed to create a therapeutic relationship. She found it "really frustrating because there was no relationship." Her client came to the clinic asking for help which she was willing to give. Alice remembered wanting to protect her client from harm due to client therapist sex and she became immediately involved with plans to confront and report the alleged offender. Her client initially agreed. As well, Alice reported:

The client said that he wanted to work on his issues arising from childhood sexual abuse, and grief related to his partner dying.... I agreed to work on these
therapy issues with him. But instead of working with me, he kept changing his agenda.... His behavior became more and more difficult.... He was using a lot of drugs and alcohol ... he threatened us with violence.... He even threatened to douse himself with gasoline and set himself on fire in front of us--in the clinic.... He would drag himself in on all fours, in an almost comatose state, and with a Lithium level of 2.1 ... toxic level.... Like he wanted everybody to see him.... I just couldn't help him. I've wondered if confrontation so early in treatment prevented me from forming a therapeutic relationship.

Research supports Alice's claim that a therapeutic relationship had not been established. Therapist qualities that prevent the formation of a relationship have received much research attention. Current research includes patient qualities which preclude a therapeutic relationship. Prochaska and Norcross (1981; cited in Lambert, 1982) found that there was an increasing consensus among therapy researchers that client qualities or characteristics account for a greater proportion of the outcome variance than do therapist characteristics. Specific qualities they cite are poor interpersonal skills and a history of poor interpersonal relationships. Alice reported that her client had both poor interpersonal skills and a history of poor interpersonal relationships.

Locating the study nurses' reflections on Focusing on the Client within the more traditional view of therapeutic relationships demonstrates how they both fit and do not fit with historical and present evolution of beliefs. After Collecting Information and Using Interventions, these three nurses turned inward, Focusing on Self, the other primary concept in the Cycle of Focusing Attention. Focusing on Self
is the process that they used to search for their mental and emotional reactions to their clients' words or behaviors. Noticing reactions is important for therapy, since study nurses used them to inform their interventions. They attended to either their thoughts or their emotions. When attending to their thoughts, the study nurses thought about the phenomenon of client-therapist sex conceptually; I have called this process Analyzing Thoughts. This important process enhanced study nurses' understanding of their clients' potential issues, making it possible for them to intervene more potently. When these nurses thought about their clients' disclosures conceptually, they remembered thinking about issues of boundary and trust violations, and of the abuse of power. In the Cycle of Focusing Attention, I have called these issues modifying-concepts and have labeled them Analyzing Boundaries and Analyzing Power. To enrich the understanding of the study nurses' disclosure experiences and these modifying-concepts, I turn first to the literature about therapeutic boundary.

**Discussion of Analyzing Boundaries**

Just as the literature about the therapeutic relationship reveals that therapists disagree about the importance of the relationship, so too the literature demonstrates that therapists do not agree on a single definition for a therapeutic boundary. In fact, the term therapeutic boundary refers to three notions, namely: the division between the professional and personal behaviors of
the therapist, the acceptability of therapeutic interventions, and the structural elements of the therapeutic relationship. How did this confusion happen?

Similar to the term therapeutic relationship, the term boundary was confused from the time of its first articulation by Freud (Lipton, 1977; cited in Gutheil and Gabbard, 1993). In the 1900s, Freud was developing and teaching psychoanalytic theory. He stated that analysts must be clear about the therapist's role, keeping their professional and personal relationships absolutely separate. This separation was the therapeutic boundary. But these instructions contradicted his own behavior. For example, when writing, Freud used metaphors involving the opaqueness of a mirror and the dispassionate objectivity of the surgeon to describe the analyst's role. However, his behavior did not reflect the abstinence and anonymity that he advocated. He sent his patients post cards, lent them books, gave them gifts, and on one reported occasion gave a patient a meal (Lipton, 1977; cited in Gutheil and Gabbard, 1993). Perhaps the most striking illustration of boundary confusion between personal and professional relationships was Freud's analyzing his daughter Anna.

This discrepancy between theory and practice was generally visible among prominent psychoanalysts of that time. Melanie Klein encouraged a patient to go on holidays with her and continue with his analysis; and Winnicott held hands with a frightened patient, and ended his sessions with
coffee and biscuits (Guthiel and Gabbard, 1993). Hence, their followers had an unclear understanding of the therapeutic boundary. Although I have used only a few examples of behaviors that are still not considered acceptable among most analysts, the literature reveals many similar examples.

Unlike these analysts, the study nurses were clear about the division, the boundary, between their professional and personal relationships. Lynne expressed it this way:

> If she's gonna come and see me, I don't want her to even think that I would cross that boundary line.... I want to be really clear and I say this is who I am; this is what I do; this is what I do not do.... I define myself really clearly ... I put up my own boundaries and I let her know who I am ... and my hope is that there's a sense of safety built in.

Alice and Cathy both recalled that they had always declined their clients' invitations to go out for coffee, and by this behavior they kept their personal and professional roles separated.

The term boundary can also be used when referring to therapeutic interventions. Orthodox analysts claim that the only acceptable intervention is an interpretation, arguing that all other comments or actions are unacceptable (Eissler, 1953; cited in Gutheil & Gabbard, 1993). They claim that all other interventions cross the boundary of acceptable analytic technique. This very limited range of acceptable interventions cause problems for less orthodox psychoanalysts and for therapists from other modalities who effectively use interventions such as clarification,
confrontation, advice and praise, suggestion and affirmation (Gutheil and Gabbard, 1993).

Like other psychotherapists, the study nurses used a variety of interventions with their clients. Since they were not trained as analysts, these nurses did not view interpretation as the only acceptable intervention, nor did they consider their active interventions unacceptable or violation of boundary.

Finally, boundary is used in relation to the structure, or the rules, of the therapeutic relationship. It can refer to a figurative membrane, or frame, which surrounds the therapeutic relationship. In that sense boundary refers to all the structural elements of the relationship and includes the following: therapists' role, the scheduling of appointments, length of sessions, arrangements for fees, office setting, gifts and services, language, self-disclosure, physical contact, and rules for emergency appointments (Gutheil and Gabbard, 1993; Herman, 1992; Simon, 1989). Alice provided an excellent example of "setting the frame" which I present later in the discussion. Herman (1992) refers to this frame as a therapy contract.

In summary, there is no single definition for a therapy boundary. A boundary may refer to any of the following: the boundary (division) between the behaviors of professional and personal relationships, the boundary (frame) around the structure or the rules of the therapeutic relationship, and the boundary between acceptable and unacceptable
interventions. I do not include this latter way of defining boundary in my discussion since it applies to analysts and the study nurses are not trained analysts. Structural and role boundaries of the therapeutic relationship, however, are relevant to the study nurses' disclosure experiences, and I now explore these more fully.

Boundaries exist for the protection of both the therapist and the client. Within the therapeutic relationship, boundaries delineate what is acceptable and unacceptable for therapist, client, and the therapeutic relationship. Clear boundaries provide safety for the client and the therapist. The therapist is responsible for making these boundaries clear and explicit. When Focusing on Self and Analyzing Thoughts, study nurses considered the principles of psychotherapy, and the notion of therapeutic boundaries. Analyzing Boundaries is the process of knowing and demonstrating acceptable therapist behavior.

Analyzing Boundaries was part of Alice's disclosure experience, when she was Focusing on Self. She thought about ensuring her client's safety, and she started by setting clear structural boundaries. Noting that the intake data revealed that her client had had difficulties with boundaries with previous professionals, Alice talked about establishing therapeutic boundaries this way:

I had to set really, really clear limits ... I had to set a really clear treatment frame [boundary]. On the first interview following the initial assessment, he was given basically a frame for how we were going to deal with his treatment.... I am a nurse, and I am here
to provide support and I would be very specific in what ways I would do that.... I give a very concrete presentation.... I would say that I will see you for supportive sessions in the office for specific amounts of time, on specific dates, once a week, for half an hour.... The other person involved in your care is the psychiatrist who is here on a consulting basis for such concerns as medication.... I made it really clear how the two people work together.... And the client has to agree to that plan.

The literature supports Alice's understanding about boundaries. Careful attention to boundaries provides client protection (Herman, 1992). When both parties agree to work within these boundaries, a safe arena for the work of therapy is constructed (Gutheil and Gabbard, 1993; Herman, 1992; Simon, 1991).

Analyzing Boundaries was also part of Lynne's disclosure experience and the process of Analyzing Thoughts. When role boundaries are clear, clients are protected. Lynne talked about how she sought to protect her client by creating a clear role boundary this way: "I define myself really clearly.... I put up my own boundaries and I let her know who I am ... and my hope is that there's a sense of safety built in." Herman (1992) supports Lynne's actions; clear role boundaries provide a safe arena for the work of therapy. Role boundaries are perhaps the most important of the three uses of boundaries cited (Gutheil and Gabbard, 1993).

Boundaries exist to protect clients from therapists' exploiting them for their own benefit. Analyzing Boundaries was part of Lynne's disclosure experience when Focusing on Self. She was very clear that she was in the session only
for her client's benefit. When her client disclosed threats and sexual abuse by a psychiatrist, Lynne kept her thoughts and feelings to herself. She revealed the following:

I thought that fucking bastard, I hope he gets it someday! ... but I don't let my fury show. I think I'm supportive to her and I say you know what he did wasn't O.K. ... I don't think it's my place to let my feelings really be all over the place, as sometimes they're feeling inside. I don't think that's appropriate. She's not coming to the session to watch me do my work, so I do it away from her time. I think my clients get a very, very clear message about boundaries from me.

The literature supports Lynne's interpretation of boundaries. Freud (cited Simon, 1991), in his principle of abstinence, stated that therapists must abstain from using clients for their own personal gratification. All therapeutic interventions are made for the benefit of clients and their treatment. Therapists derive gratification only from participating in the psychotherapeutic process and the psychological growth of their clients (Herman, 1992; Simon, 1991). Good therapeutic interventions and clear boundaries help preserve therapist neutrality, which then ensures that treatment interventions are made on behalf of the client. The personal needs of the therapist should not influence the treatment situation. The therapist's only material reward or satisfaction is payment for therapeutic services (Simon, 1991).

All boundaries within the therapeutic relationship can be crossed or violated but all crossings are not violations. If the intervention benefits the client it is deemed a boundary crossing; if it harms the client it is deemed a
boundary violation (Gutheil and Gabbard, 1993; Simon, 1991). However, Brown (1994) claims that although the client is an important source of authority on whether it is a boundary crossing or violation, many clients have experienced repeated boundary violations in the context of therapy and as a consequence have difficulty identifying their own boundaries. Brown (1994) believes that therapists carry the final responsibility in identifying boundary violations.

When Analyzing Boundaries the study nurses showed a clear understanding of boundaries, and they used this understanding when evaluating boundary violations. Cathy was very clear about the boundary between personal and professional behavior, and Analyzing Boundaries was a major part of her disclosure experience. She expressed it this way:

My client was in love with him (her former psychiatrist).... She was drawn to him like a magnet... and she would see this person and describe it as the best time she'd ever had in her life, and it was wonderful ... the hours they spent together was the most rewarding time she had ever experienced.... He made her feel wonderful ... she was totally focused on him.... She would phone him at his office or home, and she would go down to his office ... dropping into his apartment ... I didn't get the impression that he was phoning her or asking her out ... he just seemed to go along with it.... This went on for so long and I couldn't stop it ... I felt frustrated ... totally impotent.

The literature ascribes the role of boundary keeping to the therapist and instructs therapists to manage their countertransference issues. Indulging in sexual behavior with a client is a countertransference issue (Simon, 1991).
Countertransference is for the therapist what transference is for the client. It refers to all the feelings and attitudes about the client that occur in the therapist (Kahn, 1991). Freud (cited in Simon, 1991) warned that a therapist must recognize that when a patient falls in love it is because of the analytic situation and not because of the therapist's personal charm.

Cathy talked about the dangers to both her client and the offending psychiatrist when role boundaries were violated:

He set no limits.... There was a total lack of limit setting.... Then when he tried to set some limits and tried to stop the phone calls and visits she became despondent and thought her life wasn't worth living.... She took overdoses and she even threatened to kill him at one point.

This experience happened 15 years ago when, in my experience, the diagnosis of borderline personality was rarely used. Cathy's client had not been assigned that diagnosis but her behaviors suggest it now. The literature states that therapists experience great difficulty in setting limits and holding firm boundaries for fear of the patient's volcanic response to being thwarted or confronted. A patient with a borderline disorder is particularly prone to vengeful expressions of rage (Gutheil, 1989; Herman, 1992). Simon (1991) claims that patients with borderline disorders, in particular, frequently attempt to manipulate and draw the therapist out of the treatment role. They may attempt to evoke boundary violations including sexual acting
out by the therapist (Gutheil, 1989). Nonetheless, therapists are still responsible for their behavior and must not act out (Gutheil, 1989; Herman, 1992).

Boundaries exist for the benefit and protection of therapists as well and Alice talked about the protection of the therapist in this way:

This client had a blurred notion about appropriate role behavior.... He had difficulties with working with people who were his caregivers as just caregivers.... He would get involved in friendships, out of office kinds of relationships and so forth.... He has a history of borderline personality disorder and of misinterpreting behaviors of caregivers.... He said that his GP visited at home and at a restaurant ... which when you look at it in context may not be unusual, because the GP was treating his partner who was dying at home from AIDS.... When his partner died the GP gave him a hug.... But I think the GP was not really, really clear about his professional boundaries.... Anyway the client said he was having a sexual relationship with his GP.... Later when we confronted him he said that he had lied ... that the GP had only hugged him.... The client may have misinterpreted what was happening or he may not have.

Lack of absolute clarity about boundaries can lead to false accusations, and persons with borderline personality disorders constitute the majority of those patients who falsely accuse therapists of sexual involvement (Gutheil, 1989). Persons with a borderline personality disorder tend to lose the boundary between self and other when they are under stress (Gutheil, 1989). This boundary confusion, Gutheil (1989) claims, is a feature of this disorder. Although it is beyond the scope of this paper to describe the psychodynamics of borderline personality, given the susceptibility of these patients to boundary confusion,
therapists must be scrupulous, even overscrupulous, in their attention to clear boundaries and to the preservation of the professional nature of the relationship (Gutheil, 1989; Simon, 1991).

Boundaries are an important feature of therapeutic relationships and these nurses' disclosure experiences. When they are clearly and explicitly defined, they create safety for both therapists and clients. Clients with diagnoses of borderline personality disorder, due to the nature of the dynamics of this disorder, experience the most trouble staying within boundaries. Therapists must take boundary delineations very seriously. When the study nurses were Analyzing Boundaries, they demonstrated an understanding of boundaries which was clear not only to them, but is supported by literature. As they continued Focusing on Self, they were also Analyzing Power, the second modifying-concept of the Cycle of Focusing.

**Discussion of Analyzing Power**

Another means the participants used when Focusing on Self and Analyzing Thoughts in the Cycle of Focusing Attention was Analyzing Power. Power is also an aspect of the therapeutic relationship and Focusing on the Client. Analyzing Power refers to the study nurse thinking about the notion of power in the therapeutic relationships between herself and client and the offending physician and client. Hardin et al. (1985) believe:
Power is a dynamic, potential and actual force to influence another to act, think, or feel in a certain way. It operates within the confines of dependence and relationships and is actualized through use of sanctions (rewards and punishments). (p. 92)

Bacharach and Lawler (1980) claim that power is an interaction phenomenon; where there is no relationship there is no power. They also believe that dependency and sanctions are power's essential features. Dependency causes the need for exchange, and sanctions (rewards or punishments) are the actual manipulation of what happens to another.

French and Raven (1960) define power as influence and influence as psychological change. They classify power according to its sources: reward power, coercive power, expert power, legitimate power, referent power, and informational power. Legitimate power is the right to influence another based on the perception by both parties that the influencee has an obligation to accept that influence. Expert power is based on having superior skills and knowledge. Reward power is the ability to provide positive sanctions. Coercive power is the ability to apply negative sanctions to another.

The therapeutic relationship has all these essential elements of power. It is appropriate to turn again to the therapeutic relationship literature to better understand the notion of power in the relationship, the participants' disclosure experiences, and the modifying-concept of Analyzing Power. An historical review of the balance of power in the therapeutic relationship is helpful in
understanding the significant issues and in explaining what the study nurses reported.

The notion of the therapeutic relationship was derived, by Freud, from the traditional physician-patient relationship (Kahn, 1991). In matters of medical diagnosis and treatment, the physician's role of authority was taken for granted (Nelson, Nelson, Sherman, & Strean, 1968). Freud carried this medical attitude into the therapeutic relationship with the view that the patient's neurosis was an illness that he should cure. From the beginning, the structure (the patient paying for service), the role definitions (physician/analyst in the role of authority), and the therapeutic task (free association and interpretation) created a power imbalance in favor of the analyst (Kahn, 1991; Nelson et al., 1968).

Rogers (1961) envisioned a more equal balance in the relationship. He did not regard emotional difficulties as an illness that needed to be cured, and he saw a danger in comparing medicine and psychology. He refuted Freud's analogy that therapists do therapy in the same way that surgeons do surgery. He believed that therapists should work with their clients (Kahn, 1991). His manner created more equality; he not only conveyed the message that he was with the client, but also that he understood the client's experience. He referred to the person as a client rather than a patient, as well he viewed the client as a worthwhile human being who was struggling for growth and development.
However, the equality that Rogers advocated was not enough for the radical therapists of the encounter movement or the humanistic and feminist therapists. In fact these therapists objected so strongly to the power imbalance in the traditional relationship that Freud's theories were taught only in psychoanalytic institutes. In the 1970s, psychoanalysis returned to favor when the analysts, Gill and Kohut, called for more power equality and urged analysts to work with the patient (Kahn, 1991). In addition, other therapists decided to take what was useful in the theories, and leave behind what they determined as sexist (Brown, 1987).

Like the therapists in the mid-1970s, Cathy and Alice attempted to work with their clients. Cathy reported: "I wanted to help her; I listened and I understood her emotional pain ... but she kept on and on wanting to see more of him.... I could do nothing." Alice recalled: "I wanted to help ... I never really understood what he wanted."

Feminist theorists and therapists examined the balance of power in therapeutic relationships, and searched for evidence of sexism and misogyny. They claimed that therapists were oppressive and abused their power by labeling, diagnosing, and psychopathologizing normative feminine gender-role behaviors. They criticized the traditional male-model visions of human behavior (Brown, 1987, 1990, 1994), and worked towards the goal of an
egalitarian relationship. Nonetheless, feminists, who stereotypically viewed men as the abusers of power and women as their victims, were horrified to learn that some feminist therapists were sexually exploiting both women and men. By definition feminist therapists shared power with their clients and did not abuse power either sexually or any other way (Brown, 1990).

Like feminist therapists, Lynne too considered Analyzing Power to be very important. She said it this way:

Feminism is my underpinnings ... my therapy is informed by feminist theory.... One of the major things I look at in a therapy session is power, and the use and abuse of power, and how the system has treated women.... I use power wisely ... I'm really conscious of trying not to do a power trip on them.

In summary, there is unequal power in the therapeutic relationship. The therapist is typically understood as someone with special expertise, and the client as trusting, dependent, and reliant (Gabor, 1989). Humanistic and feminist theorists aspire to therapeutic relationships where all aspects of power (status, authority, and roles) are equal. However, French and Raven (1960) have identified five sources of power: clients potentially have two sources (reward and coercive power), and therapists have five sources (legitimate, expert, reward, coercive, and informational).

Having reviewed the historical highlights of power in the therapeutic relationship, I turn now to what the study nurses reported when they were Analyzing Power in the Cycle
of Focusing. As my previous discussion has shown, most therapists agree that the therapeutic relationship is the primary factor in influencing client healing and behavior. Therapists are seen as having more power than the client, and the literature supports the view that therapists have the legitimate role of healer. The client's position is seen as powerless.

When study nurses were Analyzing Power they thought about the notion of power in the therapeutic relationship between themselves and their clients, and the offending physicians and clients. Lynne spoke most clearly and emphatically about her use of power this way:

It's not my job to make people do things. My job is to be there sort of as a guide, as a listener, as a support person as this person is on their journey.... So it's not for me to, to take the bastard to court, you know, call the College, it's not what I do.... I certainly inform people what their rights are.... As a therapist in this society, I have a lot of power ... clients are vulnerable.... I use it wisely.... I try to do stuff that's empowering, or try to get them to do something that will empower themselves.

Lynne's views are similar to the feminist code of ethics which "acknowledges the inherent power differentials ... [and instructs] therapists in using it [power] for the benefit of the client, not to take control of power which rightfully belongs to the client" (Brown, 1987, p. 39). Lynne used her power to give her client power, and she reported it this way:

I ask a whole lot of questions, and then asking her whether she wanted to do ... anything about it [report the offender], I think I was empowering, rather than me saying, "I'm going to do something about it." She said
that she didn't want to do anything [and] I totally respect her.... We started talking about other things; she was quite suicidal at that point.

By informing her client of her right to report and by respecting her answer, Lynne equalized the power between herself and her client.

Alice and Cathy had very different experiences of Analyzing Power from Lynne. Cathy talked about her experience this way:

I was clear in my mind that sex with a psychiatrist is never OK.... I was frustrated in trying to work with this person.... She was determined to see him.... But thinking back, I felt kind of used at times as I was a route for her to get to see this other doctor [consulting psychiatrist] at our office. She would phone and she'd only want to speak to him, she wouldn't speak to me lots of times.... She'd fire me ... if she couldn't speak with Doctor So-and-so, she'd get so angry and hang up ... and she'd just appear in the office demanding to see him.... I tried to set some limits with her.... [Then] I thought that if that's what she wants to do there's not much I can do to prevent it. But usually these outbursts were sort of followed by a lot of remorse on her part and she would phone and tell me how much I had helped. Manipulation, I think it's called.

Clearly, Cathy was expressing feelings of frustration at being manipulated by her client, who in Cathy's opinion, was exploiting her patient role.

Alice recalled Analyzing Power this way:

The client was informed [about] how we would deal with this issue [alleged sexual abuse].... We told him we had to act on his information.... He agreed to change physicians.... The consulting psychiatrist was going to contact his [the client's] doctor.... At that point he found a new doctor; he became visibly upset by this.... In another session he came in and said that he was actually embellishing, he was lying, and that there was no sexual relationship;... there were lunches, and there was hugging. He didn't see this as a difficulty.... We still did.... He didn't want us to make an issue of it, he said he was sorry he had said
anything. And then there was another crisis;... he dropped out of treatment.... It seems so unfinished.... I felt an urgency to do something.... We put it in the client's lap, gave him the responsibility ... [and] he declined.... It's unfinished.

Both Cathy and Alice had legitimate and expert power, and their clients, by virtue of their help-seeking position, were dependent and vulnerable. But neither study nurse could effect change. Kipnis' (1974) model of seven steps of power in therapy helps us understand this situation. In this model the power of the therapist is traced throughout the therapeutic process. The steps include the following: (a) therapists, motivated by their need to be satisfied by appropriate behavior by clients, strive to influence clients; (b) clients can comply or resist; (c) therapists' legitimate role enables them to distribute rewards and/or sanctions; (d) therapists' behaviors are inhibited by consumers, the law, and their peers; (e) therapists influence clients through such efforts as persuasion, threat, reward, coercion, and support; (f) clients respond to influence; and, (g) therapists' esteem is enhanced by client compliance, and lessened by rejection.

In this model, the client's only source of power is complying or resisting (Kipnis, 1974). When Cathy's and Alice's clients used their coercive power, they nullified the legitimate power of their nurses. These clients not only refused to go along with Cathy's and Alice's health promoting suggestions, but they responded with verbal abuse and threats of physical violence.
Finally, the study nurses reported Analyzing Power in the offending physician-client relationship. They all talked about the offender abusing power in the phenomenon of client-therapist sex. Cathy said: "He [the offender] was in a position, a position of power, that she was a very fragile, dependent and, uh, distraught young woman, that he really did take advantage of the situation." Lynne admitted to being very angry when she recalled her client's situation:

He threatened her .... to have sex with him ... weekly.... She was terrified that if she didn't go along with him, he would lock her away in [a psychiatric hospital], which is what he threatened to do. So sleazy. It's just exploitative. It's total exploitation. Sexual exploitation of a vulnerable person. Everyone who comes for therapy is vulnerable.... He knew who to choose; they all do, they know what they're doing, they know how to get them to do what they want them to do. They're very powerful.... They don't pick powerful people they pick very vulnerable people ... insecure people... who don't trust their own experience.... And the psychiatrists, with all the power they have in our society, just really abuse it.

**Summary**

Lynne's statement says so much about the disclosure experience: her outrage and anger, the difficulties client-therapist sex presents to the subsequent counsellor, and it hints at the dilemma into which she is thrust, wanting to do the best for her client as well as to right past and possible future wrongs. Such issues not only provoked my beginning this study of the nurses' disclosure experiences, but also arose directly from the textual data provided by the three nurses. A paradigm describing how they handled the
disclosure emerged for me. This paradigm I call the Cycle of Focusing Attention. The nine elements of this Cycle have been discussed in detail. Three elements were found to be of particular interest and importance in the disclosure experience. Boundaries were found to be crucial because it was a boundary violation the client experienced; Power was found to be important because it was a power differential that allowed the client abuse. The significance of these elements is supported in the literature about client-therapist sexual contact. Finally, Focusing on the Client was found in these instances to constitute part of the therapeutic relationship (Focusing on Self constitutes the other part) and as such, in my view, created the environment essential for these client disclosures.
CHAPTER FOUR

SUMMARY, CONCLUSIONS, IMPLICATIONS, and RECOMMENDATIONS FOR NURSING

Summary and Conclusions

The very serious problem of client-therapist sexual contact is demanding our attention more and more frequently, either because it is occurring more often or because it is being reported more conscientiously. It is known that client-therapist sexual abuse is underreported, and this disparity between occurrence and reportage suggests that the client's disclosure presents a problem for the second professional. A review of the literature concerning the problems experienced by nurses as they resolve other types of disclosure indicates that nurses struggle with ethical and reporting dilemmas. Yet the literature does not address the subjective experience of health professionals as they are faced with the disclosure of client-therapist sexual contact. This study was undertaken to understand the disclosure experiences of three female community mental health nurses whose clients revealed sexual contact with a previous physician.

In this study, a qualitative case study method was used to understand the nurses' disclosure experiences. Case study method is flexible and systematic and can accommodate any methods appropriate for collecting and analyzing data, and qualitative methodology is generally used to uncover, describe, and understand a phenomenon about which little is
known. The principles of content analysis directed data collection and its analysis. The whole entities (case studies) were then compared and contrasted.

Three female mental health nurses, who had the experience of clients disclosing sexual contact with a former physician, participated in this study. These study nurses' experiences were intensively explored using unstructured interviews. The audiotaped interviews were transcribed verbatim. Using content analysis and working independently of each other, a reviewer and I analyzed the transcriptions. Once concepts were identified, two participants were re-interviewed in order to clarify and deepen my understanding (one participant went on an extended holiday and could not be re-interviewed).

The comparative, qualitative case study approach proved to be the appropriate choice of method for exploring this important but under-documented area of clinical practice. This method provided access to the phenomenon under study by the following means: (a) it facilitated an indepth understanding of three individual disclosure experiences, (b) it was flexible and systematic enough to accommodate any methods appropriate for collecting and analyzing data, (c) it could be used in a restricted time frame, (d) it used the restricted number of informants who were available, and (e) it maximized the use of their separate and different disclosure stories.
The findings emerging from these case studies indicated that the three nurses were involved in a complex, cyclical, cognitive, and behavioral process of focusing their attention. In this process, called The Cycle of Focusing Attention, the nurse alternately focused her attention on the client and on herself, with the goal of alleviating client suffering. Contained in the Cycle of Focusing Attention were: two concepts, Focusing on the Client and Focusing on Self; four sub-concepts, Collecting Information, Using Interventions, Experiencing Feelings, and Analyzing Thoughts; and two modifying-concepts, Analyzing Boundaries and Analyzing Power.

When the nurse was involved in this Cycle, her attention continually alternated between Focusing on the Client and Focusing on Self. When Focusing on the Client, the nurse listened to her client and observed her/his behavior. When she was Focusing on Self, she turned inward and processed the information she received while listening to the client and observing her/his behavior, and she noticed her personal reactions (feelings or thoughts) to it. Then, based on the results of her mental processing, the nurse returned to Focusing on the Client and made a verbal, non-verbal, or behavioral intervention. This refocusing on the client began another cycle. This process was overlapping and continuous, and not discrete and linear as the limitations of language would make it sound.
Focusing on the Client was comprised of two sub-concepts, Collecting Information and Using Interventions. When Focusing on the Client the nurse was involved in the cognitive process of compiling data by listening to her client, and observing her or his behaviors (Collecting Information), or she used this data to inform her verbal, non-verbal, and/or behavioral response (Using Interventions).

After Focusing on the Client, the nurse reported turning inward to search for her mental and emotional reactions to the client's words or behaviors. Termed Focusing on Self, this concept was comprised of two sub-concepts, Experiencing Feelings and Analyzing Thoughts. Analyzing Thoughts was the mental process the nurse used to think conceptually about the therapy issues embedded in the client's disclosure. Analyzing Boundaries and Analyzing Power were two modifying-concepts of Analyzing Thoughts; they served to illuminate the dynamics embedded in the phenomenon of client-therapist sexual contact. When Analyzing Boundaries, the nurse thought about crossed therapy boundaries which allowed client-therapist sex to occur; when Analyzing Power, she thought about the power differential that allowed the client abuse. The final sub-concept refers to the nurse's attending to her own emotional responses: Experiencing Feelings represented the nurse's noticing and naming her internal physical sensations in response to the client's revealing sexual contact.
The analysis was enhanced by the use of literature, both in the form of knowledge that I brought to the research as part of its fore-structure, and that which I sought out in order to illuminate the emerging concepts during analysis. Relevant literature was used to develop three major elements from the Cycle: Focusing on the Client, Analyzing Boundaries, and Analyzing Power. The nurse's disclosure experience was more fully explained and elucidated through this discussion.

A number of conclusions emerged from the Cycle of Focusing. Study nurses experienced very strong feelings of moral outrage and powerlessness at the physicians' misuse of personal and professional power. Further, these feelings did not lessen with the passage of time.

Despite their personal feelings, the nurses maintained their professional demeanor and consistently treated their clients in very caring and respectful ways. They focused their attention on their clients and on their implicit goal of alleviating client suffering. Even when their clients were displaying difficult behaviors, the study nurses continued to care about them and to intervene in potentially helpful ways. Client physical safety, as well, was a primary concern.

Study nurses were immediately certain that the physicians' sexual behavior was unethical. They labelled it unethical and/or wrong and voiced this to their clients.
Study nurses revealed that they were knowledgeable on two levels. They understood the therapeutic needs of their clients related to client-therapist sexual contact. They also understood the social and ethical demands of reporting.

Finally, the disclosure experience was vivid in the nurses' minds, although two to fifteen years had intervened. Study nurses had little trouble clearly remembering the details and circumstances of the actual disclosure, the behaviors and concerns of their clients, or their own emotional and intellectual responses.

**Implications and Recommendations**

The findings from this study of mental health nurses' disclosure experiences have implications for nursing practice, research, education, and administration. The case study method established the existence of a phenomenon, and the comparison of multiple cases showed that the phenomenon was experienced by more than one nurse and was not, therefore, wholly idiosyncratic (Miles & Huberman, 1994). Inductive findings illuminated in detail the dynamics of each particular case, but were not generalizable to a population (Miles & Huberman, 1994) and constitute only the beginning of a detailed description of the phenomenon. The description generated modestly contributes to nursing's body of knowledge and may enhance nursing practice, research, education, and administration in the following ways:
Practice

The finding of the conceptual framework which emerged from the examination of these disclosure experiences contains the potential for particular usefulness in situations of client disclosures. If this conceptual framework were available to them, nurses could then be aware of the movement and rhythm of the process which lies ahead of them in dealing with disclosure. The nurses' confidence and effectiveness would be enhanced by this foundation. The framework could be used as a map, guiding them in choosing interventions and thinking conceptually. It could point the way through an important issue so that nurses would not get lost in subjectivity and outrage. In addition, this would provide reassurance when they are being introspective about their experience(s).

The findings that despite the passage of time, study nurses had little trouble remembering the details of the disclosure experience, that the intensity of their feelings also did not diminish with time, and that their personal feelings included moral outrage, suggest that the nurses found the disclosure experience complex and challenging. Therefore, it is important for nurses to take the status of their own mental health very seriously and actively care for themselves.

Recommendation: Critical incident debriefing and/or clinical supervision would be appropriate actions.
Given the finding about the difficulty inherent in this practice situation, nurses involved in disclosure experiences should be acknowledged and praised for their exemplary nursing care.

**Recommendation:** Information about their exemplary care could be disseminated orally from person to person, in published literature, and at professional meetings including briefings in the work place.

**Recommendation:** Qualitative research could be conducted to explore how expert nurses intervene successfully and effectively with clients who disclose sexual contact.

**Research**

The findings of this study have meaningful implications for nursing research. The development of a conceptual framework, The Cycle of Focusing Attention, suggests further research which would support, extend, or refute it.

**Recommendation:** This framework could be extended by the addition of data from other "cases"; or the phenomenon could be extended using other qualitative methods, such as phenomenology, Grounded Theory, or naturalist inquiry. Obtaining a sufficient sample remains a concern, although exposure in the literature may help nurses to come forward and identify themselves.

The findings that time does not lessen the intensity of feelings about the disclosure and that study nurses had little trouble clearly remembering the details and circumstances of the disclosure suggest the disclosure had a
strong impact on these nurses. This indicates the need for further inquiry into the aftermath of disclosure for the second therapist. This knowledge would increase the nurse-therapist’s self-awareness as she works with client disclosure situations.

**Recommendation:** An exploratory study determining the nature of this impact on the second therapist.

It was found that the case study was a useful method to solve the research problem and to accommodate the time and sampling concerns. As well, it provided a manageable but comprehensive experience with data collection, data analysis, and reporting the findings. This positive experience may encourage student researchers to publish their findings and do more research.

**Recommendation:** Encourage the use of case study method in nursing for master’s theses. Case study is suitable for the beginning study of related phenomena and when samples are small because of ethical concerns. This method provides nurses with an excellent way of reflecting on and evaluating nurses’ practice.

**Recommendation:** Encourage students to publish findings of their research, and establish means (infra structure support) to assist them in doing so.

**Education**

The findings of this study have only indirect implications for nursing education. These findings apply equally to the training programs of RNs and RPNs. Although a
theoretical framework was discovered it cannot be used in curricula until other studies replicate, extend, and support it. As well, although the majority of the findings suggest that the disclosure of client-therapist sexual contact is a significant issue for these nurses, these findings must be validated through more research. However, parts of the data could be informally shared with students in their clinical groups, and with others at professional inservices.

**Recommendation:** Students could be taught that sexual abuse between professionals and clients does occur and that they may hear about it at some point in their practice.

**Recommendation:** In clinical groups, students should be encouraged to explore, and talk with each other about their thoughts and feelings concerning client-therapist sexual abuse.

**Administration**

The findings of this study have implications for nursing administration. The findings that study nurses revealed knowledge about the therapeutic needs of their clients and social and ethical requirements (reporting procedures), consistently maintained their concentration on their implicit goal of alleviating client suffering, clearly identified the physician's sexual behavior as immoral and immediately addressed this issue with their clients, and demonstrated expert nursing care in a difficult practice situation suggest that nursing administrators should more openly acknowledge such exemplary nursing practice. This
acknowledgement would provide these nurses with some recognition and gratification, which in turn would enhance job satisfaction and perhaps performance.

**Recommendation:** Administrators should suggest and facilitate nurses' needs for recognition and debriefing. For example, they could sanction and initiate the creation of critical incident debriefing groups, facilitate inservice opportunities, and sanction and support professional counselling for the nursing staff.

**Summary**

This research is important because it has illuminated a significant aspect of the sexual abuse phenomenon. The nurses' experience of client disclosure of sexual contact with a former therapist was shown to be a difficult and stressful nursing experience. The research has implications for nursing practice, research, education, and administration. If attention is paid by the nursing system to these implications, clinical practice will become even more effective, and suffering of both client and nurse will be decreased.
REFERENCES


Appendix A

Initial Trigger Statement

Please tell me a little about what it was like for you to have your client disclose sexual contact with a therapist
Appendix B

Respondent Consent Form

A Mental Health Nurse's Experience when a Client Discloses Sexual Contact with a Former Therapist: A Case Study

In signing this document, I am giving consent to be interviewed by Marg Rae, a graduate student at UBC. I understand that she is interested in studying my experience when a client disclosed to me that she had had sexual contact with a former therapist. This study will provide in depth information to nurses and other professionals about one person's experience with this situation. The results of this study may support and guide other professionals in understanding the issues related to reporting client-therapist sexual contact, and start generating knowledge about this phenomenon.

I understand that being a respondent in this study will involve being interviewed and audiotaped in a setting which is convenient to me and that my involvement may require two to four separate interviews of one hour duration. Interviews will be transcribed into written form.

I understand my name and any other identifying information will not be revealed when reporting the results of the study. My identity will be known only to Marg Rae since she will use a special code to identify my interviews when she transcribes the audiotapes.

I understand that the anonymity of the offender and the agency will be ensured, and that any mention that I may make to them when I am interviewed will not appear in the transcripts.

I have been informed that I am under no obligation to participate in this study, and that I am free to terminate my involvement at any time without jeopardy. Similarly, I have been informed that I may refuse to answer any questions during the interview(s). I am aware that I may experience some psychological discomfort as I talk about my experience. I understand that if this happens, and I request it, Marg Rae will promptly arrange for appropriate and mutually agreeable therapeutic interventions. As well, I have been informed that I will not receive any financial benefit from my participation in this study.

I understand that the results of this study will be made available to me if I request them, and that Marg Rae is the person to contact if I have any questions or concerns regarding my participation in this study. I can contact Marg Rae at 682-1994. In addition, I may contact her committee.
members Clarissa Green (822-7507), Virginia Hayes (822-7477), and Janet Ericksen (822-7505); or members of the Ethics Committee (822-8584).

I, the undersigned, understand the nature of Marg Rae's study, and I give my consent to participate as a respondent in her study. I acknowledge receiving a copy of this consent form.

Date: Respondent's name:

Respondent's phone number:

Respondent's signature: