The black and white and shades of grey of boundary violations

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Summary Using a Constructivist Grounded Theory approach (Charmaz, 2006), this research examined the social construct of the "professional boundary" necessary in mental health therapeutic work and the problem of professional boundary violations in the therapeutic relationship. Thirteen mental health clinicians from various professional disciplines commonly found in mental health clinical practice responded to three specific questions designed to gain an understanding about how clinicians gauge the differences between minor and serious boundary violations. The three questions facilitated further exploration of boundary violations specifically to explore the difficulties of determining what is and what is not considered a boundary violation often resulting in polarised views or "black and white" descriptions and opinions. However many shades of grey were also revealed during the interviews.

Almost all participants rated intimacy or sexual contact with a client or an ex-client as being a serious boundary violation, on the other hand there was a great deal of variety in the examples offered as minor boundary violations. Whilst the "Black" is clearly defined by clinicians in this research, the "White" only seemed to create more "Grey" areas, with descriptions of behaviours that fell into the Grey area being more difficult to define.

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1. Introduction

The concept of the professional boundary first appeared in early psychodynamic theory. Gabbard (1999) examined the problem of boundary violations in psychotherapy citing Freud's (1915) work on "Transference love", where Freud states that it would be disastrous for the patient and the treatment if the analyst was to act upon a
patient’s sexual overtures. Very early in the development of psychoanalytic theory, Freud acknowledged that a boundary exists between the patient and the therapist, and that this boundary should not be crossed. Healthcare professionals today recognise that in order to sustain a therapeutic relationship there has to be a professional boundary between the client and the healthcare provider. Crowden (2008, p. 10) reinforces the difficulties experienced by today’s health care professionals and states ‘The moral status of professional boundaries and the ethical nature of dual and multiple overlapping human relationships in contemporary clinical practice remain enduring problems in all health care disciplines.’

The concept of boundaries in mental health clinical practice was presented by Guthel and Gabbard (1993) in what has been described as ‘...a landmark article’ (Pope & Keith-Spiegel, 2008, p. 639). Guthel and Gabbard’s original paper attempted to provide a framework for further debate and discussion on the issues of professional boundary maintenance in clinical practice (Pope & Keith-Spiegel, 2008). However Peterson (1992) had previously uncovered many of the problems confronting various professionals including clergy, mental health clinicians and law practitioners, and is now considered a seminal piece of work on professional boundary violations. Peteson clearly described the professional boundary as a mechanism that protects ‘...the space that must exist between the professional and [the] client...’ (Peterson, 1992, p. 46).

Using a Constructivist Grounded Theory (Charmaz, 2006) approach, this paper reports on interdisciplinary perceptions of professional boundary violations in the therapeutic relationship. Research participants (n = 13) self-selected to be interviewed from the professional disciplines of Mental Health Nursing, Psychiatry, Psychology, Occupational Therapy and Social Work. Interviews were semi-structured intensive interviews (Charmaz, 2006) with guiding questions being developed from initial scoping of the professional literature related to professional boundaries, boundary maintenance and therapeutic relationships.

Interview participants had to have a minimum of five years clinical experience working in community mental health services with a focus on rehabilitation and recovery. Many of the clients using these services would have been engaged in a voluntary capacity whilst others would have been compelled under Community Treatment Orders. Questions directed to clinicians were general in nature about the management of professional boundaries and no distinction was made about the legal status of the client. Therefore the responses are understood as being broad in nature relating to how mental health clinicians establish and negotiate the professional boundary in a general sense.

2. Methodology

Using a Constructivist Grounded Theory approach as described by Charmaz (2006) this research explored the phenomenon of how mental health clinicians establish and maintain the professional boundary in their day-to-day practice. The interpretive nature (McClelland, 2000), of this theoretical perspective was seen as being consistent with contemporary mental health practice (Gardner, McCutcheon, & Fedoruk, 2012), where the mental health clinician seeks to understand and work with the client’s unique understanding of their illness and conceptualisation of wellness (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). The Constructivist Grounded Theory approach aligns well with the Recovery model (Amering & Schmolke, 2009) which is predominantly used in mental health care settings in Australia and internationally.

3. Methods

Ethics approval to conduct this research was gained through the University of South Australia (UniSA) Human Research Ethics Committee. After the initial UniSA ethics approval was granted subsequent permission to conduct the research was approved through the relevant industry partner’s health service ethics committees.

Data was collected from interview transcripts, interview notes made by the researcher during each interview, and memos written by the researcher throughout the research process demonstrating the reflexive nature of this research approach (Gilgun, 2010). The main source of data for analysis was the interview transcripts. Participants were asked to respond to ten broad guiding questions during the interviews which lasted approximately one hour. More specifically, the final three questions of the interview were designed to gain some understanding about how clinicians gauge the difference between a minor boundary violation and a serious boundary violation. The final question of the interview asked participants to reflect on boundary concerns that they were unsure about, but consider that the behaviour may constitute a boundary transgression. This question was designed to elicit further discussion about the issues of boundary violations to explore the difficulties of determining what is and what is not considered a boundary transgression. By asking participants to reflect on boundary concerns encouraged participants to recall events in clinical practice where they became concerned about behaviours which may have compromised the professional boundary.

Data collection and analysis were conducted throughout the research using the constant comparative method (Charmaz, 2006), and included three coding phases — initial coding, focused coding and theoretical coding (Charmaz, 2006). Data collection and analysis were conducted simultaneously with each interview informing the next interview as successive data sets were collected and analysed.

3.1. Initial coding

Initial coding was used to name concepts as they were identified by the research participants. An in vivo code uses the unique words or phrases that interview participants use to describe certain events, actions or a descriptor of the phenomena being studied. Some of the in vivo emerging codes, for example engaging clients, establishing and maintaining boundaries, being friendly and using therapeutic leverage were analysed and further developed as more data was collected in subsequent interviews.
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