"We deal here with grey": A grounded theory of professional boundary development in a forensic inpatient service.

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Abstract

Background: The question of how to maintain appropriate professional boundaries with clients in mental health settings can be complex, particularly for forensic inpatient nurses and healthcare workers. The literature in this area to date has mainly focused on boundary violations with little research on how staff members develop and maintain boundaries in forensic inpatient units, despite safe working relationships being beneficial for staff experience and client recovery.

Method: Interviews with eleven psychiatric nurses and healthcare workers from forensic inpatient wards were analysed using a grounded theory methodology.

Results: A cyclical model of boundary development was developed in whichstaff initially acclimatize to the forensic environment using their existing experiences and personal values before entering a calibration phase, where they constantly assess and address professional boundary issues in the course of their daily responsibilities. Staff members use this experience alongside reflection, social learning and clinical supervision to undergo individual learning and team development. In the fourth phase, staff members use this learning to recalibrate their views on boundaries, themselves and how they work with clients. This recalibration impacts on staff members' further management of daily boundaries providing more material for learning, which leads to further recalibration.

Conclusions: This study echoes previous literature suggesting the importance of supervision and reflective spaces in professional boundary understanding. The model is comparable to existing learning theory and highlights the importance of social and experiential learning. There are implications for forensic psychiatric nurses in terms of training, team building, supervision and provision of reflective spaces.

Keywords: nurse, healthcare worker, professional boundaries, development, forensic, inpatient

Introduction

The benefits of good working alliances for client recovery have been well documented (e.g. Hewitt & Coffrey, 2005). Professional boundaries represent a core component of working relationships, however they are often vaguely defined (Peternelj-Taylor, 2002) and require a large degree of subjectivity to manage. Safe boundaries can facilitate a secure space that protects both parties and the therapeutic alliance, while boundary violations can cause harm to either party, their relationship and the service.

While managing professional boundaries may be difficult for all health professionals, the varied and intimate roles psychiatric nurses and healthcare workers hold may make facilitating effective and safe boundaries particularly difficult for these staff groups. They tend to spend more time with clients than other professionals, which can cause confusion about where the relationship begins and ends (Peternelj-Taylor, 2002; Peternelj-Taylor & Yonge, 2003). Within the concentrated nature of this working relationship, professionals may experience a "seductive pull" towards helping a client (Peternelj-Taylor & Yonge, 2003; p55) or experience problematic emotional responses to powerful client interactions. In forensic inpatient services, the nature of the work, the client group and the secure environment all contribute to the intensity of relationship dynamics.

Forensic mental health services in the UK include high, medium and low security hospitals, alongside some prison, controlled access and community-based services. Clients often have a history of offences that will already have shown their potential to misunderstand or overlook societal and legal boundaries, such as violence, sexual assault and fire-setting. Many will have had difficult early experiences that limited their exposure to and understanding of appropriate relationships (Coid, 1992). Experiences of abuse or neglect by

primary caregivers could lead to problematic attachment styles and defences that may influence later relationships with staff (Adshead, 2012). Clients who have experiences of abandonment or feeling cast out of familial or friendship groups may re-experience intense emotional responses to this in the ward environment, where they are segregated from society. Those who have been neglected, ignored, controlled or abused in earlier life and potentially later institutions may learn survival strategies in forensic wards, such as projecting difficult feelings onto staff, or splitting and dividing teams (Townsend, 2015). Forensic nurses and healthcare workers may therefore find themselves needing to manage the distress of client early experiences, alongside their own emotional reactions to clients, their offences and the threat of risk. Their own experiences and vulnerabilities will impact on their ability to manage these issues and prevent entering into re-enactments of clients' past dysfunctional relationships. Additionally, some of their professional responsibilities, such as enforcing security procedures and contributing to clients' risk assessments, can heavily impact on the power differential between the client and the professional, where such duties may affect a client's privileges and discharge (Kelly & Wadey, 2012; Peternelj-Taylor, 2003).

Research has also suggested that forensic nurses and healthcare workers may be particularly vulnerable to burnout (Dickenson & Wright, 2008) and staff-client relationships have been highlighted as an important influence on staff wellbeing (Ministry of Justice, 2011; Moore, 2012). The constant, draining experience of battling with client emotions and behaviours may lead to exhaustion, pessimism about the effectiveness of treatment, compassion fatigue and under-involvement in the therapeutic relationship. This may be a particular concern when working with clients diagnosed with personality disorder as qualitative studies have reported nurses can feel exhausted, incapable, devalued and overwhelmed while caring for this client group (Aiyegbusi & Kelly, 2015; Woollaston &

Hixenbaugh, 2008). Caregivers may therefore become stuck in a cycle whereby they become overwhelmed due to challenging interactions with clients and withdraw and become under-involved in their care to preserve wellbeing. Clients may consequently experience this as a rejection or abandonment and respond with more intense emotion, which overwhelms the caregiver further.

Although the above literature suggests maintaining professional boundaries may be particularly difficult for nurses and healthcare workers in forensic services, knowledge around *how* these staff groups develop their understanding of boundaries in these settings is scarce. Currently, information on this subject is patchy and comes indirectly from qualitative research in related areas. Jones and Wright (2015), for example, found that nursing students were aware of professional boundaries when trying to engage clients in a forensic setting, yet they did not appear to have a clear understanding of the concept. Further studies (Aiyegbusi & Kelly, 2015; Woollaston & Hixenbaugh, 2008) suggest the importance of self-awareness, training and reflective spaces in maintaining a professional, therapeutic footing. However, the mechanisms which may make these processes helpful to development are not yet understood.

Aims of the current study

In summary, the literature around nurses' and healthcare workers' boundary management in inpatient forensic services is small and focuses primarily on difficulties or violations. While the need to share and document challenges is understandable, the opportunity to explore how staff members think about and develop boundary practice could be equally valuable by helping clinicians and services to understand how safe, therapeutic relationships could be facilitated and supported. The current study therefore aims to address this gap in the literature.

Methodology

Recruitment

Nurses and healthcare workers were recruited via an email advert from three medium secure forensic inpatient wards in the UK, with one ward (A), being an acute unit where mental health symptoms were more severe and florid than the sub-acute (C) and rehabilitation (B) units. Medium secure wards typically provide assessment, treatment and rehabilitation for adults with complex mental health needs who pose a moderate risk to others. Most clients will have had contact with the criminal justice system and will stay on the unit for an average of 18-24 months (NHS Confederation, 2012). Staff based primarily in low secure wards were excluded, although it was noted that staff sometimes worked across different units and may have been drawing on these experiences during the audio-recorded interviews. A semi-structured interview schedule was used initially, although questions and areas of enquiry changed throughout the process to elucidate richer categories as the theory developed (Charmaz, 1996). Questions generally asked about processes and changes over time (What do you find helpful when thinking about boundaries? Has this always been the case? What has led you to see this as helpful?), as well as the meaning of personal experiences (Can you give me an example of that? What do you think of this experience looking back? Did anything change in your practice after that experience?). After eleven people were interviewed, the first author considered that theoretical sufficiency (Dey, 1999) had been reached as no new themes were being identified. Data analysis began after the first interview had been transcribed and continued concurrently with data collection. Interviews lasted an average of 40 minutes each.

Participants

The eleven participants comprised a range of ages and levels of experience and included staff of both genders. The average age of the sample was 38 years. Attempts were made to recruit participants who did not identify as White British, as it was thought that different ethnicities might produce richer categories, however this was unsuccessful. Table 1 shows demographic information for all participants.

Ethical Considerations

This study received ethical approval from relevant university and NHS ethics panels. Participants were given at least 24 hours to consider information sheets and were encouraged to ask questions about the study in order to provide informed consent. Participants were advised that data would be handled confidentially and that they could withdraw from the study at any time. Any data received from them until the point of withdrawal would be destroyed.

Data Analysis

Interviews were transcribed and analysed by the first author within a constructivist paradigm that acknowledges the researcher role in analysis (Charmaz, 2014). Initial codes were generated from each transcript using line-by-line coding and then grouped into tentative categories that reflected the most frequently occurring codes. Codes and categories from later transcripts were added and compared to those of previous transcripts so that possible re-groupings could occur. Memo writing and diagramming helped to explore potential connections between categories, shaping the resultant theory from an early stage in analysis (Charmaz, 1996). A reflective diary helped to explore the researcher's influences on the data

and a model of the theory was shared with participants before finalisation to see how they made sense of the researcher's interpretations. Participants felt that the model resonated with their experiences on the wards and provoked thoughts about service development recommendations.

Results: A cyclical process

Data analysis resulted in a cyclical model of professional boundary development consisting of four main categories (in bold) and 21 subcategories (in italics; see Figure 1 for a visual depiction of the model). The model suggests that staff move through four main phases of boundary development during their time in forensic services, starting with **acclimatisation** to the setting using their previous experiences and personal values. In phase two, **calibration**, staff constantly assess and address difficulties related to boundaries in the course of their daily duties. Staff undergo individual and team **learning** in phase three, which they use in phase four to recalibrate their views about boundaries, themselves and how they work with clients. This **recalibration** is suggested to impact on their future management of boundaries, which in turn affects learning and further recalibration, so that staff move in a continual development cycle through phases two to four. These phases my not occur as distinctly as they are portrayed in Figure 1 and may overlap.

Phase 1: Acclimatisation

This phase describes participants' experiences of *adapting to a new environment*, where naivety and lack of knowledge around boundaries could sometimes made it harder to

manage boundaries initially, particularly for young, less experienced staff members. Staff members relied on rules where possible, although they later realised the limitations of these guidelines.

> ***When I started working here and doing mental health training and stuff, you sort of get this idea that these are the rules, this is how you are and how you work with people. You don't do this and you don't do that. But actually, it's not that simple (Participant A, Ward B)***

Participants described coming into the service at either end of a boundary continuum, with most acknowledging being initially too firm in their approach. Being new was noted by clients on the ward, although it also meant receiving support from more experienced staff.

Participants described how *integrating their personal values* and *drawing on pre-service experiences* helped them to adapt. They described acting initially in ways that were in line with their own characters and experiences.

> ***"I'm a person at the end of the day and you're a person - my upbringing, my values, morals, principles, that's my basis, that's my grounding point for how I move on." (Participant K; Ward A)***

They also acknowledged the impact of previous personal and professional experiences on their boundary management when they first arrived and felt that it was particularly beneficial to have had some prior experience in mental health settings.

"There are some people that will come in and be very boundaried, you will find that they generally have mental health experience or some form of experiences within the health kind of setting and there'll be people that have come in straight from university, if they're a nurse, or straight from school and they like mental health because they've got someone in their family that suffers with something or their friend suffers with something or they might even suffer with bits and pieces themselves, but they don't understand the boundaries." (Participant K; Ward A)

Phase 2: Calibration

After their early experiences, participants described beginning to *lay the groundwork* for future boundary management by thinking about how to protect their personal information, gathering information about clients and thinking about client attachment styles. Knowledge of their clients was highlighted as being key to understanding how to manage individual boundaries.

The really important bit about knowing the patient is 'ok, that's what I need to set up with that patient because they are going to potentially try and push a little bit more than somebody else (Participant F, Ward B)

Staff acknowledged *encountering constant boundary issues* and the task of managing these dilemmas appeared central to staff members' work on the ward. They spoke about enforcing rules and managing interpersonal relationships with clients, highlighting several ways of managing these aspects. *Accepting uncertainty* in boundary management was seen as vital, although this was also uncomfortable for both staff and clients.

> ***We deal here with grey…As I said there are certain black and white boundaries in terms of no, you can't have a relationship with a patient, no you can't be giving them money … but the majority of our boundaries and rules are all grey areas which is open to interpretation, which is horrible. Patients don't like that, staff certainly don't like that, but what can we do? (Participant K, Ward A)***

Participants found it difficult when there was no definitive answer to boundary dilemmas, although they acknowledged a need to be flexible. Often, they found themselves *struggling with balance* when trying to facilitate working relationships that were neither too strict nor too lax. They also felt that boundary management depended a lot on balancing potentially competing demands, such as maintaining a positive relationship with clients, enforcing security procedures, reducing risk and promoting reintegration into the community. Participant K, for example, described a trade-off between staff safety and client learning when trying to follow ward procedures with clients who protested rules.

> ***It would be very easy for me at these points to say 'oh let's just give in because I won't get death threats'…. What does that achieve? How are you helping that patient at that point in time? When they go out to society you can't just go around the streets just doing what you want, there are rules. (Participant K, Ward A)***

Participants often linked more lax boundaries with increased risk to themselves, however they also noted that being strict could equally put staff at risk. Giving some personal information to clients, for example, could enhance trust in relationships, which was thought to reduce risk incidents.

Forging individual relationships was also seen as important. This included using different boundaries with individual clients according to the age, gender and characteristics of both staff and client. Consistency within these individual relationships was also promoted.

> ***I get the youngsters coming to me as a mother figure and sort of saying, you know, 'look I'm having trouble and I'm really bad and I don't know what to do'. They're looking for a bit of reassurance and comfort…. I wouldn't use that with everybody (Participant C, Ward C)***

Using instinct and self-awareness could be helpful, for example using clinical judgement to inform responses to clients or acknowledging gut feelings. Some participants noted becoming aware of a tendency to avoid difficult boundary situations, for example with clients with a diagnosis of personality disorder. Alternatively, people also reported *clarifying and confirming* actions around boundary dilemmas with experienced staff and acknowledged team support during decision-making.

> ***Nine times out of ten I believe I've made the right decision because I'm experienced and confident but it, it's just getting the manager or someone higher saying 'yeah, I agree' (Participant C, Ward C)***

Finally, participants emphasised the importance of *communicating with clients* explicitly around boundary issues, explaining decisions and conveying empathy.

> ***You have to find that balance between saying 'this is the rules, however I do understand…it must be really hard for you' (Participant J, Ward A)***

Phase 3: Learning

During this phase, participants spoke about developing their boundary management practice individually, via four interacting processes, and as a professional team. *Gaining vocational experience* was seen to be central to individual boundary practice development, as more time on the ward increased exposure to different boundary situations and heightened awareness of risk issues.

> ***They work on very minimal staff here so there's a lot more one on one contact…. you can't rely on someone else to kind of step in …. so I think maybe because of that they do, they do learn it and they pick it up and they develop that themselves" (Participant F; Ward B)***

Participants noted the importance of *reflecting on practice,* which included learning from mistakes and being willing to develop their self-awareness and professional knowledge.

> ***I built up a really good therapeutic relationship with one of my patients a few years ago and he told me something….I did end up sharing it because I knew it was the right thing to do but I left it for a day, because I needed to sleep on it…..but, in hindsight I should have done it straight away….you do learn from reflection, you learn from, you know, thinking about what would the consequence be if I didn't report that straight away and I went home and I thought about it and I thought 'shit! He's just shared that information with me that is really important and I've left him with it. I'm not even on the ward, I can't look after him'…. So I, I've learned that. So you do learn by the little things. (Participant C; Ward C)***

Using clinical supervision, both individual and group, was seen as an opportunity to gain feedback and have open discussions about personal experiences on the ward.

> ***I think it's more healthy to bring up things rather than bury them and hope they go away, so like, 'oh actually, let's talk about this - I did this the other day, what do you think about that?' (Participant D, Ward C)***

Staff members noted that psychologists helped them to consider patient presentations and formulations, while senior nursing staff encouraged supervisees to reflect on their practice and decision-making. This was also touched on in *social learning,* where staff members described opportunities to learn from each other, exchange different perspectives and offer support.

The process of *team development*, where staff members described responding to difference and disagreement with conversation and compromise, appeared to interact with individual learning.

> ***It's again finding that balance and getting the team talking to each other…we'll have that discussion and we'll meet in the middle (Participant C, Ward C)***

This was also done in multidisciplinary forums, where the team gained cohesion by explaining and justifying the unique position and boundaries of their role to other disciplines.

Barriers to development, which impeded learning were also identified, these included hiding mistakes, being defensive about actions, lacking self-awareness and being complacent.

Complacency – they always say the big C - complacency is one of our biggest issues (Participant K, Ward A)

Phase 4: Recalibration

In this final phase, staff described using what they had learned to adjust their understanding of boundaries, themselves and how they work with clients. These adjustments affected their management of future daily boundary issues and therefore began a cycle of continual development over time.

Staff members noted *refining boundary understanding and adjusting the scale* of boundary strictness. This included gaining a deeper understanding of the use of boundaries and making bi-directional adjustments to their boundary management, becoming firmer in some areas and less firm in others.

There are times that I've thought 'oh yeah actually, I can see that you can work this way, you don't have to be as strict about that'. There's other times where I go 'yeah this is not the way to work, I definitely think that in this sort of situation you do need more rigid boundaries' (Participant A, Ward B)

Participants also described *personal growth*, including becoming more confident and relaxed, having increased resilience and having more finely tuned instincts. They spoke frequently about the potential for ever-increasing development. As a result of refined understanding and personal growth, staff members talked about *changing their practice*, for

example altering both how they managed boundaries and how they continued developing them, for example becoming more active in supervision.

> ***If [staff] are guided and if they're prompted you do notice changes … then they might get a bit more confident with patients to be able to say not 'I'm not going to talk about that' because sometimes that can upset the patients (Participant F, Ward B)***

More experienced participants spoke about using their learning to influence *service development* by improving training, promoting open ward cultures and empowering their colleagues. This development, in turn, affected the experience of new starters.

Discussion

The cyclical model outlined above suggests that nurses and healthcare workers acclimatise to the forensic inpatient environment before learning more about their approach to boundaries through their experiences of frequent boundary issues over time. This learning can be applied to future boundary situations, which can promote further learning. Participants initially felt naive and ignorant with regards to boundaries, which supports previous findings that student nurses in forensic wards did not appear to understand boundaries clearly (Jones & Wright, 2015). This indicates that although there may be a more superficial knowledge of boundaries earlier on, a deeper and more refined understanding perhaps is gained over time through clinical experience. Previous research has emphasised the need for support and reflective spaces in order to maintain professional relationships and it was clear from the current study that being part of a reflexive team was key to personal and clinical

development. However, nurses and healthcare workers are expected to report boundary concerns involving other staff, which might create an internal conflict in individuals weighing up professional responsibility with the risk of creating friction amongst colleagues. Fisher (1995) found that people working with individuals who could pose risks to staff tended to prioritise relationships with colleagues over reporting responsibilities as they depend on the wider team for their safety. This supports recommendations for open, forgiving cultures where staff feel safe to explore their feelings and practice around boundary dilemmas (Peternelj-Taylor & Yonge, 2003). Additionally, suggestions that team support and supervision helped participants feel relaxed and resilient in their roles supports findings that colleague support is important in reducing burnout among forensic mental health nurses (Melchior et al, 1997; Coffrey & Coleman, 2001).

Participants discussed both procedural and relational boundary dilemmas, indicating that they found it difficult to balance reinforcing ward rules and routines whilst building therapeutic relationships with clients at times. Staff thoughtfulness around these relationships may contrast with ideas that forensic mental health clients experience stigma or negative perceptions from health professionals due to their diagnoses or offences (Adshead, 2012; Markham & Trower, 2003; Forsyth, 2007). Participants' stories of building relationships with clients suggest they were mindful of distancing themselves from clients, as well as becoming too involved. They acknowledged that empathy was a factor in gauging professional boundaries and they discussed wanting to facilitate things for clients while taking into account ward and treatment guidelines.

There was also evidence that participants battled with client emotions and hostility in a way that challenges relationship-building and reflects theoretical ideas around the way that

clients perceive and respond to an inpatient environment. Participants reported clients getting upset and angry with them, as well as dismissive and distant; however, these difficulties were often discussed in the context of what helps staff to learn to manage these inter-relational encounters more effectively and confidently. There was an emphasis on knowing your client, considering attachment styles, using consultation from psychology colleagues and using supervision and reflection to avoid getting into dysfunctional dynamics.

It is of note that the model from this study is similar to Kolb's (1984) experiential learning cycle. Both theories emphasise the value of reflecting on vocational experience in order to apply what they have learned to future situations, so that practice evolves over time. Similarly, the way that participants described supervision sounded comparable to the concept of scaffolding (Wood, Bruner & Ross, 1976), as supervisors provided active, focused support for boundary learning.

Clinical Implications for Forensic Nurses

As the first study to examine the process of professional boundary development in forensic services, there are evident clinical implications for nurses and healthcare workers. It would appear useful to increase vocational learning opportunities and consider mentoring schemes for nursing students and newly qualified staff, as well maximising staff reflective spaces generally. Additional opportunities for team building and peer supervision might help to enhance trust amongst the nursing team and develop open cultures. Specialised training programmes could help to normalise feelings of uncertainty inherent in ethical decision-making and relational working, while discussion groups in collaboration with clients could be particularly useful for working relationships, given that previous research has suggested that

clients in forensic services also feel most uncomfortable about relational aspects of boundaries (Schafer & Peternelj-Taylor, 2003).

Clinical and forensic psychologists could increase opportunities for nurses and healthcare workers to explore shared formulations of client relationship difficulties. Additionally, service managers might consider assessing potential nursing candidates on characteristics such as openness and self-awareness during recruitment, which may align well with the NHS values-based recruitment framework (Health Education England, 2016).

Limitations and Research Implications

While this study provides a richer understanding of the processes involved in developing professional boundaries, plenty of questions remain. Further research, for example, could clarify whether particular supervision models or reflective approaches are more useful than others. Additionally, many of the helpful processes for boundary development in this model rely on the use of voice and it is perhaps concerning that the participant sample in this research was not ethnically diverse, despite nurses and healthcare workers in forensic services comprising a range of cultural backgrounds. Hearing from different voices using a more ethnically diverse sample could illuminate whether the mechanisms described in this model apply equally to forensic nurses and healthcare workers from different backgrounds, or whether there are other helpful mechanisms that have not yet been shared.

Conclusion

This study is the first to explore how nurses and healthcare workers in inpatient forensic services develop their understanding and management of professional boundaries over time. The findings provided a cyclical model of professional boundary development, where supervision, reflecting on practice, social learning and vocational experience were all key to learning. The model emphasises the care and attention that nursing and support staff dedicate to boundary issues and highlights the team process in working through difference to achieve understanding and compromise. The model of development is comparable to existing learning theory and this has important implications for training, experiential learning, peer supervision and enhanced opportunities for reflective spaces. Further research could explore cultural aspects of personal boundary management and investigate the specific mechanisms within different supervision and reflective practice approaches that may be most helpful for staff.

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