BREACHING THE NURSE-PATIENT THERAPEUTIC RELATIONSHIP:

A GROUNDED THEORY STUDY

By

Margaret Sue Pennington

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and recommend that it be accepted as fulfilling the dissertation requirement for the Degree of Doctor of Philosophy

Terry A. Badger, PhD, RN	Date 5/8/02
Carrie Jo Braden, PhD, RN	Date 5/8/02
Judith Berg, PhD, RN	Date 5/8/02
Ronald J. Vogel, PhD	Date 5/8/02
Theodore H. Koff, PhD	Date 5/6/02

Final approval and acceptance of this dissertation is contingent upon the candidate's submission of the final copy of the dissertation to the Graduate College.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

Dissertation Director	Date 5/8/02

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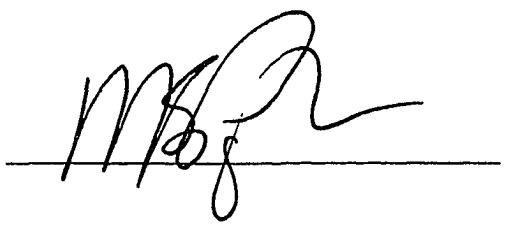
SIGNED: 

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DEDICATION

This dissertation is dedicated to my non-nursing colleague, co-worker, and friend, George Gafner, MSW, CISW. It was his proactive style of thinking and acting that led to the creation and formation of the Southern Arizona VA Health Care System Boundaries Team in 1986. George included me in this noble venture at the onset, and I am grateful for the rich experiences and opportunities it has afforded me. I have admiration, respect, and love for George; there are no boundaries to my gratitude.

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ABSTRACT

The therapeutic nurse-patient relationship is the core of nursing practice. This grounded theory study used symbolic interactionism, identity theory and ethics as a theoretical perspective to examine nurse-patient relationships. The opinions and experiences of twelve professional nurses were explored to discover the process and events involved when a nurse engaged in a nontherapeutic relationship with a patient. A core process, Breaching the Nurse-Patient Relationship, was identified from the interviews. The core process identified three stages in the process with conditions in each stage that showed progression from each condition in each stage to the next stage. The first stage in the process revealed five conditions that make the nurse vulnerable for engaging in nontherapeutic activities with a patient. Stage one, with the five conditions, was the preliminary process that lead to stage two. In stage two, the nurse engaged in nontherapeutic activities/relationships with the patient. The nurse was either under-involved or over-involved in the nurse-patient relationship but clearly the nurse deviated from the therapeutic realm of the relationship. There were eight conditions in stage two that identified the process of the nurse leaving the therapeutic role to engage in a nontherapeutic role with the patient. The last stage was characterized by the consequences that the nurse, patient and profession of nursing had to face as a result of the nontherapeutic nurse-patient relationship.

CHAPTER ONE

INTRODUCTION

The nurse-patient relationship is a vital component to health outcomes for any patient (Forchuk, 1992; Forchuk and Brown, 1989; Jerome and Ferraro-McDuffie, 1992; Peplau, 1952). The nurse-patient relationship is a vehicle designed to assist the patient in accomplishing his/her health goals. The knowledge, skills and expertise of the nurse are important attributes of the nurse in meeting the patient's health goals because patients depend on nurses for assistance in meeting health care needs.

This study examined the process when the nurse moves from a therapeutic nurse-patient relationship into a nontherapeutic relationship. This study sought to discover the beliefs, attitudes and perceptions of the nurse regarding the nurse-patient therapeutic relationship and what influence ethics, morals and educational factors had in guiding the nurses behavior. Patients, as consumers of health care services, may be irreparably harmed by incompetent or unethical health care providers (Barnsteiner and Gillis-Donovan, 1990; Coleman and Schaefer, 1986; Feldstein, 1993; Laury, 1992; Sherman, 1993; Siegel, 1992). Patients may also be harmed by caring, well-intended, but over-involved health care providers (Barnsteiner and Gillis-Donovan, 1990; Gutheil and Gabbard, 1993; Kagle and Giebelhausen, 1994; Siegel, 1983). The health care market is different from other markets because it includes a greater demand for consumer protection from harm by health care professionals (Feldstein, 1993). Consumer protection in the health care market has been in effect through federal

government regulating, monitoring and influencing health care systems, healthcare quality and outcome since the early 1900s (Feldstein, 1993; Vogel, 1999; Williams and Torrens, 1993). Regulatory and review mechanisms, such as State Boards of Nursing, monitor the practice of nursing, including the domain of the nurse maintaining a therapeutic relationship with the patient.

The professional nurse-patient therapeutic relationship is complex and challenging. The therapeutic relationship of the nurse and patient is considered the core of patient care (Cholniere, 1991; Fochtman, 1991; Peplau, 1952; Pilette, Berck and Achber, 1995) and the phases of the therapeutic relationship development have been well described (Forchuck, 1992; Forchuk and Brown, 1989; Heifner, 1993; Jerome and Ferraro-McDuffie, 1992; Krikorian and Paulanka, 1982; Peplau, 1952; Peplau, 1969).

The therapeutic relationship is based on the theory that the patient has an innate drive toward health (Jerome and Ferraro-McDuffie, 1992). The therapeutic relationship is the interpersonal process whereby the nurse uses himself/herself (as self) to motivate and move the patient toward health and healing. The nurse provides the patient with information, empathy, nondirective listening, respect and feedback as actual treatment and nursing interventions (Peplau, 1952). For example, the nurse uses scientific expertise to provide information on diabetic diets, symptoms of insulin reaction and administering insulin. Empathy and nondirective listening are used to understand the fears and concerns of adherence to the diabetic life-style that are now

necessary for the patient. Feedback is provided by the nurse to support, redirect and reinforce the patient's understanding of administering the injections, recognizing disease symptoms and attaining necessary knowledge to maintain health care. Respect is demonstrated by the nurse toward the patient at all levels. These are extremely valuable aspects of the interpersonal process. Knowledge can be imparted by the nurse but without empathy and respect, the patient does not feel as free to express fears and concerns. It is through that interpersonal process, and giving of self by the nurse, that the patient attains higher levels of health care goals. It is the nurse-patient relationship that serves as a vital component to the patient's health outcomes, and it is that relationship that is the focus of this study. In the following sections, the background of the problem, purposes, research questions, significance to nursing and theoretical perspective will be presented.

Background of the Problem

The importance of nurses maintaining a therapeutic relationship with patients will be addressed in this section. The explanation of therapeutic relationship and the zone of helpfulness, the nurse-patient relationships, including aspects of caring, moral activities and power will be presented. Terminology relevant to nurse-patient relationships will be discussed.

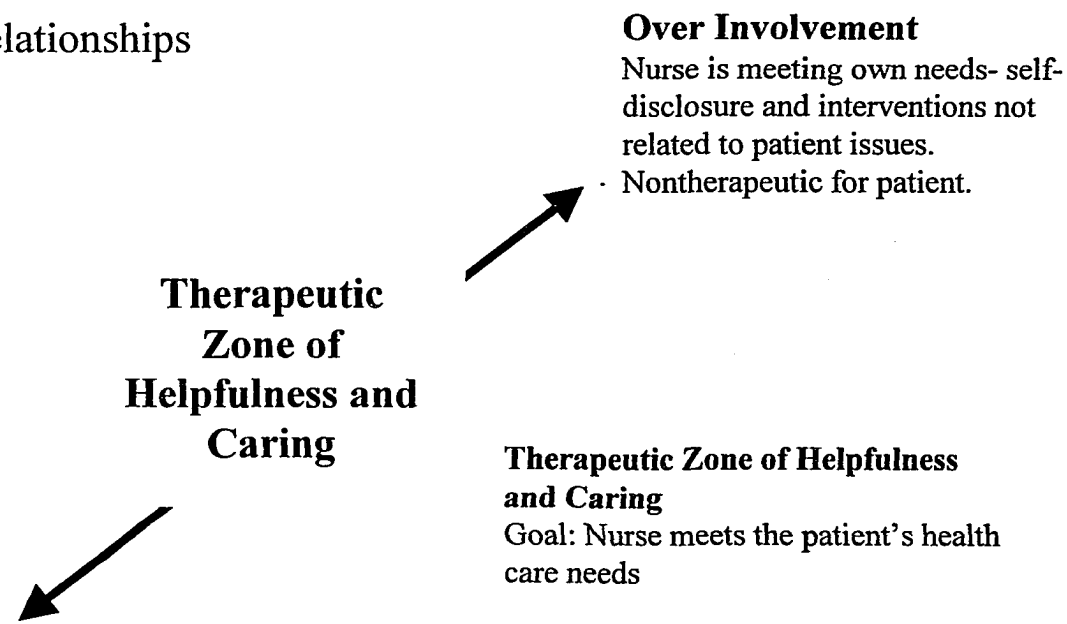
Therapeutic Relationships and Zone of Helpfulness

The therapeutic relationship between the nurse and patient encompasses the interpersonal process that facilitates the patient moving toward health and healing.

Inherent in the therapeutic nurse-patient relationship is a zone of helpfulness and it is in the therapeutic zone of helpfulness where the nurse works with the patient to meet the patient's goals and to attain the patient's maximum health. The therapeutic zone of helpfulness is helping the patient - but helping in the right amount. The right amount means not too much or not too little. Inherent within the therapeutic zone of helpfulness is caring. Again, caring enough to help, but not too much or too little.

When the nurse is involved with the patient outside the zone of helpfulness, it may be possible to commit boundary violation. Boundary violations are defined as when the nurse moves from the therapeutic zone of helpfulness of meeting the patient needs and patient goals for health to a nontherapeutic zone of meeting the needs of the nurse. For example, a nurse who spends off-duty time with a patient, or talks about his/her personal/social life excessively, or accepts and expects gifts/favors from the patient has moved out of a therapeutic zone of helpfulness to a nontherapeutic zone of being overly involved. Although these examples may often constitute mild deviations from the therapeutic zone of helpfulness, it is clear that the goals for the patient's maximum health is no longer the priority. Conversely, a nurse can move out of the therapeutic zone of helpfulness by being distant, cold, aloof and noncaring. In this example, the nurse will not likely be involved in a boundary violation but as above will function outside of the therapeutic zone of helpfulness. Again, the patient goals are sacrificed (see Figure 1.1).

Figure 1.1 Nurse-Patient Relationships



Note. "Nurse-Patient Relationships" from M. S. Pennington, (1996). Podium Presentation at American Psychiatric Nurses Association 10th Annual Conference, La Jolla, California.

It is sometimes a challenge for the nurse to remain in the therapeutic zone of helpfulness, particularly since a nurse spends most of the 24 hour day with the patient. Nurses are often caught in the crossfire of exhibiting humanistic caring behaviors toward patients without becoming overly emotionally involved. Maintaining this therapeutic balance in the nurse-patient relationship is essential yet it is sometimes unclear exactly where the therapeutic line (boundary) ends and a personal relationship begins (Scott, 1988). Most disciplines (e.g., psychiatry, social work, psychology, nursing) acknowledge the existence of a therapeutic zone in staff-patient relationships. These disciplines identify the zone of therapeutic helpfulness as being where the therapeutic interactions between the professional and patient occur, and state it is essential to have a therapeutic zone of helpfulness in order to meet the goals of health. However, despite the numerous articles and texts written (Gallop, 1993; Gutheil and Gabbard, 1993; Munsat and Riordan, 1990; Pennington, Gafner, Schilit, and Bechtel, 1993; Pilette, Berck, and Archber, 1995; Sabey and Gafner, 1996) and the numerous surveys conducted (Epstein and Simon, 1990), the literature does not show evidence of work that is *grounded.* A useful contribution of this study will be to transcend the previous works while integrating them into this new study and theory. The predominant theme of concern addressed in the literature about the therapeutic relationship, or staying in the therapeutic zone, was to avoid sexual exploitation of the patients. Psychiatry (Appelbaum, and Jorgenson, 1991; Epstein and Simon, 1990; Epstein, Simon and Kay, 1992; Gutheil and Gabbard, 1993; Herman, Gartrell, Olarte, Feldstein, and Locallio, 1987; Kluft, 1989; Laury, 1992), nursing

(Barnsteiner and Gillis-Donovan, 1990; Gallop, 1993; Munsat and Riordan, 1990; Pennington, et al., 1993; Pilette, et al., 1995; Sabey and Gafner, 1996), social work (Kagle and Giebelhausen, 1994), psychology (Pope, , Keith-Speigel and Tabachnick, 1986; Schoener and Gonisiorek, 1988; Schoener and Milgrom, 1989), and counseling (Coleman and Schaefer, 1986; Levenson, 1986) are disciplines concerned with the professional remaining within the therapeutic zone. In addition, patient rights advocates have also addressed staff sexual exploitation (Siegel, 1983, 1991, 1992, 1993) and have pursued legislative action to prohibit staff moving out of the therapeutic zone of helpfulness. These extant works will contribute toward developing a substantive theory of the therapeutic zone of helpfulness of the nurse-patient relationship. The next section will emphasize the importance of the nurse-patient relationship and how the concepts of caring, moral activities, and power influence the relationship.

Nurse-Patient Relationships

Nurse-patient relationships will be discussed with an emphasis on the importance of the nurse understanding him/her self as a person. This self-understanding by the nurse is the foundation of the nurse-patient relationship but concepts of caring, ethics, morals, power and helpfulness will be discussed as important elements in the nurse-patient relationship

The crux of the nurse-patient relationship is an understanding by the nurse of who he/she is as a person and as a professional nurse. It is important for the nurse to be aware of his/her needs (Scott, 1988). Unmet needs can serve as a motivation in the care of patients and such motivations can stimulate behaviors in the nurse that may not be toward

meeting the goals of the patient (Jerome and Ferraro-McDuffie, 1992). Each individual nurse's awareness of self, as a person and as a nurse, impacts the nurse's ability to sustain a therapeutic relationship (Jerome and Ferraro-McDuffie, 1992). The things that the nurse values, dislikes, fears or seeks to avoid are powerful influences in sustaining the nurse-patient relationship. If the nurse seeks to avoid expressions of anger by a patient, as this stirs up painful and fearful emotions in the nurse, the nurse will likely be motivated to avoid or limit the amount of time he/she spends with angry patients. On the other hand, if the nurse values the patient verbalizing anger, sees such ventilations as therapeutic and is comfortable to listen to the patient, the nurse will integrate such interventions into the plan of care goals. Unless the nurse is cognizant of what he/she values, what needs he/she has, what he/she feels about him/her self as a person and as a nurse, many behaviors will be acted out without an awareness of what has motivated the action. The harm of the nurse not having an understanding of self is that many opportunities will pass in which the nurse will not be engaged in the most meaningful nurse-patient relationship simply because the nurse does not realize that his/her personal dynamics are influencing his/her actions with patients.

Additionally, the nurse must understand what is his/her responsibility and what is not. It is important for the nurse to know what are the personal and professional boundaries within the relationship. Healthy personal boundaries help define self and carry over to positively influence the professional nurse-patient relationship.

Caring

In nursing, the core of nursing is defined as caring. Caring implies closeness. In the

nurse-patient relationship, there are definitions addressing appropriate closeness in the therapeutic relationship (Peplau, 1969). For example, a nurse may spend extra time with a very frightened and critically ill patient, holding the patient's hand while listening to the intimate expressions of fear by the patient. Some nurse-patient relationships presume more closeness than others. Life issues of birth, death, illness and dying involve a high degree of emotional intimacy. The balance between appropriate closeness and intimacy and appropriate distance are difficult to define. When the nurse becomes too enmeshed in the patient's issues, objectivity and separateness can be lost (Barnsteiner and Gillis-Donovan, 1990). On the other hand, if the nurse remains distance and aloof, the patient is denied the opportunity for emotional intimacy and growth.

The literature and clinical practice is confusing about what is the right amount of caring. Some nurses who exhibit caring behaviors may become over-involved with patients and suffer negative consequences. In contrast, some over-involved nurses may receive commendations and awards and be cited as "going beyond the call of duty." The nursing literature stresses the importance for the nurse to remain separate yet related to be a therapeutic agent (Barnsteiner and Gillis-Donavon, 1990). Peplau (1969) maintained that professional closeness means the nurse has enough emotional involvement with the patient to facilitate the patient's recovery but not enough emotional involvement to drain the nurse's energies, becloud the nurse's perceptual field and distort nursing observations.

Moral Activities

Sarvimäki (1988) and Curtin (1979) argues for a view of nursing care as a form of moral activity. From these moral perspectives, the nurse-patient relationship is based on the nurse's commitment to help the patient toward something good. The moral and ethical values of the nurse are considered important aspects in the nurse-patient relationship and each nurse brings social, ethical, moral, cultural, familial and educational definitions of caring that influence the therapeutic realm of the nurse-patient relationship.

Power

In the nurse-patient relationship, the role of the nurse begins with more power and authority. However, the power and authority of the nurse has built-in limits mandated by regulatory agencies (National Council of State Boards of Nursing, 1995). Nurses can use their power and authority to make things happen. For example, nurses may inspire patients to move through a chronic illness process to achieve levels of health that he/she might not attain without the nurse using the power inherent in the role. Even when nurses do not feel powerful, it is important for the nurse to be aware of the power and its impact on patients. This burden of power and authority imposes responsibility (Peterson, 1992) and nurses should use and respect the influence of power and authority inherent in the nurse-patient relationship. Otherwise, nurses may, unknowingly, abuse this power over patients to meet the nurse's needs.

In summary, since nursing theorists maintain the nurse-patient relationship to be

an essential aspect of the nursing paradigm, (Fawcett, 1984; 1989; Fitzpatrick and Whall, 1989; Peplau, 1952) and since many nursing scholars advocate the inclusion of morals and ethics as an integrated aspect of the practice of nursing (Bandman and Bandman, 1994; Carper, 1986; Sarvimäki 1988; Watson, 1985) and since the predominance of the literature addresses case studies, statistics of surveys with recommendations for preventive and corrective actions for maintaining therapeutic relationship and avoiding sexual encounters with patients (Averill, Beale, Benfer, Collins, Kennedy, Myers, Pope, Rosen and Zoble, 1989; Bouhourtsos, Holroyd, Lerman, Forer and Greenberg, 1983; Epstein, et al., 1992; Epstein and Simon, 1990; Gabbard, 1989; Gartell, Herman, Olarte, Feldstein and Localio, 1986; Gutheil and Gabbard, 1993; Herman, et al., 1987; Jorgenson, Randles and Strasburger, 1991; Kardner, Fuller and Mensh, 1973; Vinson, 1984), and most importantly, since there is a lack of a grounded theory on nurse-patient therapeutic relationships, it is vital to hear from nurses who have had experience with nurse-patient relationships, both therapeutic and nontherapeutic to generate a theory from these nurses. This study, with data grounded from experienced nurses, will serve to proactively understand and explain the human world of the nurse-patient therapeutic and nontherapeutic relationship. The data is important because it is derived from experienced nurses; it is their values, perceptions, and beliefs that come from their nursing experiences with nurse-patient relationship. The grounded theory of nurse-patient relationships was generated from experienced nurses facing the nursing challenges in today's society.

Purpose of the Study

The purpose of this study was to examine the process of nurses moving from a therapeutic nurse-patient relationship with patients into nontherapeutic relationships. This issue needed to be addressed with nurses who have had such experiences, either personally or professionally as co-worker or supervisor, to understand the guiding beliefs, attitudes and perceptions of the nurse, the psychodynamics of the contextual situation, and the outcomes. The nurse's beliefs, values, perceptions of the therapeutic nurse-patient relationship were examined to learn what influence ethics, moral and educational factors had on the nurse's behavior. A grounded theory methodology was used to facilitate the discovery process.

Research Questions

The prominent focal question of this research study was: By what process or events did the nurse engage in a nontherapeutic relationship with the patient? Additional heuristic questions that provided a framework for understanding the first question are:

1) What, if any, is the special bond that makes the nurse-patient relationship therapeutic?
2) When does the nurse cease to be therapeutic?
3) How much helpfulness/caring is therapeutic?
4) How much helpfulness is too much/not enough?
5) How can a nurse be close and distant in a therapeutic relationship?
6) Where and how did you develop your beliefs/values about the nurse-patient relationship?

7) In your opinion, what circumstances lead to the nurse leaving the therapeutic zone of helpfulness and becoming over/under involved with the patient?

The specific aim of this qualitative research was to discover and understand what were the roles, beliefs, values and perceptions of the nurse who engaged in a process of leaving the therapeutic zone of helpfulness with a patient. It was important to discover from nurses who had life experiences in the situation. Nursing theorists present the ideal role for nurses to follow in a therapeutic nurse-patient relationship. However, caring and concerned nurses digress from the therapeutic zone of helpfulness to engage in relationships with patients that are outside the therapeutic zone of helpfulness. In order to discover what contributing circumstances lead to this digression, a purposive sample of nurses with such experiences was selected. This research contributes to an understanding of what leads a nurse to engage in a relationship with a patient that is outside the therapeutic zone of helpfulness.

Significance For Nursing

Nursing is a discipline which focuses on the relevance of the nurse-patient relationship in the healing process. The nurse-patient relationship pervades every health care setting in society. There are 2.2 million professional nurses currently employed in health care settings (U.S. Department of Labor, 2002). Each nurse has influence on the patient through the nurse- patient relationship. The significance of this study to the profession of nursing is not merely through the sheer volume of nurse-patient encounters. Of equal important is that nursing, as a profession, must be concerned with its

constituent nurses to practice nursing by helping patients attain a maximum level of health.

The profession of nursing has the responsibility to monitor individual members of the profession. Nurse-patient relationships are an integral part of every nursing situation and every nurse should know what constitutes a therapeutic nurse-patient relationship. The nursing profession needs to be aware of any and every serious deviation in the nurse-patient relationship. One major consequence of nurse-patient relationship becoming nontherapeutic is the irreparable harm that may be caused to all parties: patient, nurse and nursing profession. The harm involved may include physical, emotional, financial, and legal harm. Many nurse-patient relationship violations carry the potential for media sensationalism. This can be extremely damaging to the profession of nursing. Patients, as consumers of health and nursing care, expect protective and caring behaviors from nurses. Those caring, helpful and protective behaviors are the salient features of the zone of helpfulness. The trust and expectations of society's members toward the profession of nursing may be tarnished with deviations from the zone of helpfulness to boundary violations.

The costs involved in the reporting/investigating procedures for misconduct cases of nurses is expensive and time consuming (National Council of State Boards of Nursing, Inc. 1995). Nursing as a profession has affirmed its commitment to society to protect patients in the therapeutic nurse-patient relationship (National Council of State Boards of Nursing, Inc. 1995). This study has the potential for discovering data from nurses who

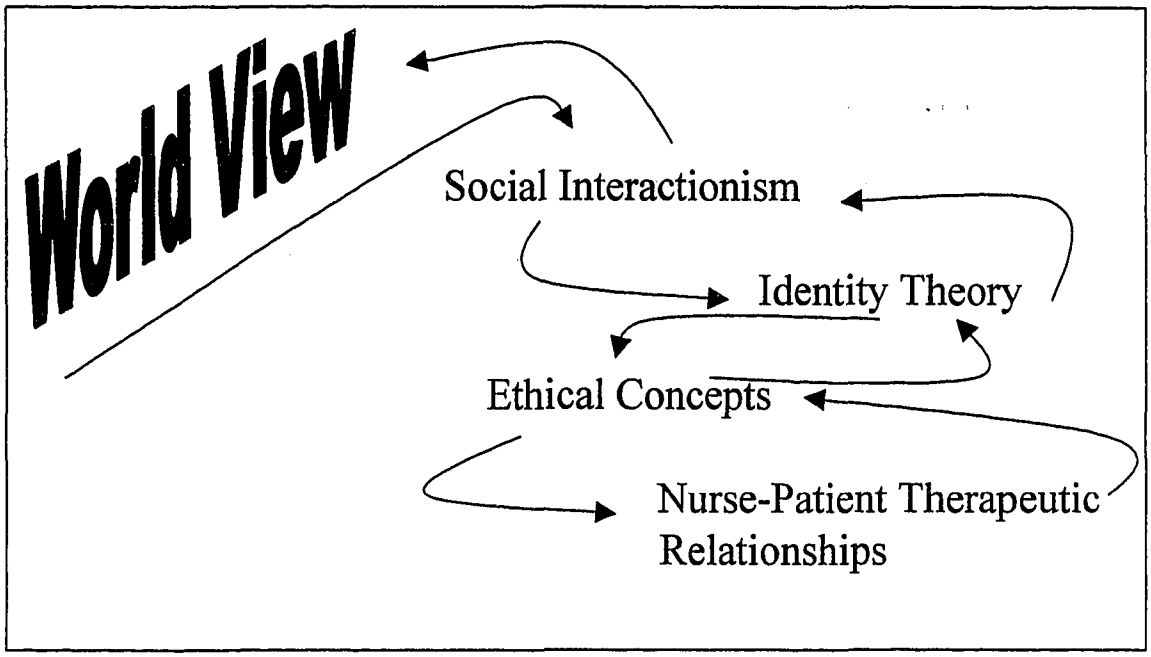
have had experience with boundary violations that has heuristic value toward theory development. The data may be used as preventive and educational strategies to assist nurses in remaining in the therapeutic zone of helpfulness while avoiding boundary violations.

In summary, the significance of the study to nursing practice will ultimately be determined by its utility and relevance to clinical nurse-patient relationship situations (Glaser and Strauss, 1967). The information gained will increase nurse's awareness of the importance of the nurse-patient relationship hopefully. The evaluation and analysis of this study has some potential heuristic value for nursing education programs and State Boards of Nursing.

Theoretical Orientation

This section provides the theoretical orientation to the research. In the first part the theoretical perspective provides an orientation to the researcher's contextual world view, the concepts and underpinnings of symbolic interactionism and identity theory. Relevant ethical concepts are presented with underpinnings of these to nursing and lastly, a synthesis of the theoretical perspectives is provided (Figure 1.2).

Figure 1.2 Theoretical Orientation



Contextual World View

The three most familiar world views in the study of human development are mechanistic, organismic, and contextual (Hultsch and Deutsch, 1981). The mechanistic world view is associated with a reactive organism. The metaphor of the person is to a machine reacting to the environment, with the functioning of the various parts dependent on forces outside the person. The goal of the person is to establish equilibrium and balance.

The orgasmic world view is an active organism and rejects the view of person as a passive receiver of stimuli from the environment. The whole is more and greater than the sum of parts.

The world view of contextualism, which is the world view of this investigator, is conceptualized by reality being a process of dynamic, ongoing and continually changing patterns. Events are interconnected. One's actions and behaviors are the result of reciprocal interactions between other individuals in a particular contextual situation, both of which are continually changing. In order to understand the reality of any situation, the phenomena or situation at the time must be examined in context. Individuals are continually affecting and being affected by changing contexts. This contextual world view leads to a dialectic paradigm which will be addressed in the synthesis section.

Symbolic Interactionism

The theoretical perspective of symbolic interactionism is an approach to understanding and explaining society and the human world and is related to grounded theory (Crotty, 1998). Grounded theory methodology is informed by the symbolic interactionism theoretical perspective (Crotty, 1998). It offers a perspective on life, society and the world. The focus is on the connection between *symbols* and *interactions.* Symbols are shared meanings such as language while interactions are verbal and nonverbal actions and communications (La Rossa and Reitzes, 1993). Only through dialogue can we become aware of the perceptions, feelings and attitudes of others to interpret their meanings. Symbolic interactionism provides a frame of reference for "understanding how humans, in concert with one another, create symbolic worlds and how these worlds, in turn, shape human behavior" (La Rossa and Reitzes, 1993, p. 136). Symbolic interactionism is important to this research because the central focus is to

understand how nurses who have experienced boundary violations created symbolic meanings in the relationships that shaped their behaviors to leave the therapeutic realm of the nurse-patient relationship. Symbolic interactionism provides an orientation to help discover values, perceptions and beliefs of nurses about the core elements of the nurse-patient therapeutic relationships.

The origins of symbolic interactionism stem back to the early 1900's with the pragmatic views of George Herbert Mead. Symbolic interactionism has three basic interactionist themes (Blumer, 1969). La Rossa and Reitzes (1993) outlined seven assumptions that are integrated into the three themes of Blumer (1969). These assumptions are under each theme.

Table 1.1

Themes of Interaction

I.	**Meaning for Human Behaviors**
	Assumptions
	1. Human beings act toward things on the basis of the meanings that the things have for them.
	2. Meanings arise in the process of interaction between people.
	3. Meanings are handled in and modified through an interpretive process used by the person dealing with things he or she encounters.
II.	**Development of Self-Concepts**
	4. Individuals are not born with a sense of self; it develops through social interaction.
	5. Self-concepts provide a motive for behavior.
	6. Individuals and Society have relationship freedoms and constraints.
III.	**Individuals and small groups are influenced by larger cultural and societal processes.**
	7. Individuals work out the details of social structure through social interaction in everyday life.

Meanings for Human Behaviors

The first theme addresses the importance of meanings for human behavior and includes three assumptions. The first assumption, *human beings act toward things on the basis of the meanings that the things have for them* (Blumer, 1969), is relevant for this

study to understand conscious thought and cognitive meaning between stimulus and response as well as meaning between feelings and actions. For example, nurses may behave rudely toward substance abusing patients because these patients represent a collective group of irresponsible people to the nurse. Conversely, patients may respond to the female nurse in a condensing manner because nurses represent a lower class type citizen, such as that depicted by Dickens' (1812-70) of the Sairey Gamp character: a drunken, sloven care-giver.

The second assumption is that *meanings arises in the process of interaction between people* (Blumer, 1969). Interactions take place over time and it is important to examine the cognitive processing of the nurse and patient. For example, what evolved in a nurse-patient relationship that changed the relationship into a romantic-sexual relationship? It is important to discover when the conversation changed and in what context. What happened to the nurse-patient relationship and when did the nurse begin to see the patient as a potential lover?

The third assumption of the first theme is that *meanings are handled in and modified through an interpretive process used by the person in dealing with things he or she encounters* (Blumer, 1969). Patients and nurses interpret reality through symbols and shared social meanings of their culture. The nurse's white uniform, the red cross on the nurse's scrub suit, the nurse with lamp (angel of mercy) are symbols that have shared meaning in American culture. Nurses see patients as objects in need of help, usually wearing hospital gowns or pajamas.

Development of Self-Concepts

The second theme addresses the development and importance of self concepts. The fourth assumption relevant is that *individuals are not born with a sense of self but develop self concepts through social interaction* (Blumer, 1969). Nurses develop a concept of self as a nurse through the professional interactions with others. Nurses may have developed concepts about who and what is a nurse in childhood encounters with a nurse. The role identity development is an integral part of every nursing program. The social interactions of nurses in the classroom, the clinical settings, the professional organizations and the media serve to facilitate the development of the self as a nurse.

The fifth assumption is *self concepts, once developed, provide an important motive for behavior* (La Rossa and Reitzes, 1993). Self-values and self-beliefs affect behavior and influence the behaviors in the therapeutic relationship. If the nurse has a view of self as a nurse to carry out doctors' orders in a robot fashion, the behaviors exhibited by the nurse are likely to be mechanical. The nurse is less likely to engage in any in-depth assessments or interventions beyond the specifications of the "doctor's order." If, on the other hand, the nurse has a self-belief that he/she is an equally important health care team member and believes that the nursing assessments/interventions affect the patient's health care outcomes, regardless of doctor's orders, then more engaging behaviors of the nurse with the patient are likely to occur. Self-concepts are complex but serve as a strong motivating force for an individual's behavior.

Individual and Society

The third theme focuses on the social process and the relationship between the freedom of the individuals and the constraints of society. The sixth assumption is *individuals and small groups are influenced by larger cultural and societal processes* (La Rossa and Reitzes, 1993). The individual nurse's behavior is constrained by societal norms and values codes. Nurses as individuals are influenced by peers, employing facility policies, state laws, national codes of ethics and by societal processes.

Nurses are influenced by the clinical area of practice. A nurse behaves differently in the pediatric, geriatric, psychiatric or medical-surgical settings. However, there are codes of ethics and standards of practice that guide a nurse's behavior regardless of clinical site. Society demands behaviors from nurses that are congruent with professional/ethics health care standards.

Finally, the seventh assumption *that through social interaction in everyday situations that individuals work out the details of social structure* (La Rossa and Reitzes, 1993). The dynamic character of social structure is extremely important. Social situations are influenced by the attitudes and subjective definitions of the situation as held by individuals. Social structure in America is complex. Nurses have earned society's trust, respect and authority to provide health care to its members in times of sickness and emergencies.

In summary, symbolic interactionism is used as a theoretical perspective for this study because of the powerful perspective it offers in understanding nurses behavior in the context of the nurse-patient relationship.

Identity Theory

Identity theory is one of several thought provoking theories that has served well in enhancing the conceptual framework of symbolic interactionism (La Rossa and Reitzes, 1993). Of particular relevance to this study is Stryker's (1980) identity theory. According to Stryker (1980) "identifies" refer to self-meanings in a role. Thus, within the role of nurse, the individual nurse constructs an identity. The relevance of self-identity as a professional nurse has enormous implications for the behaviors of the nurse. If the nurse views him/her self as being "called" to be a nurse, the identity takes on a moral and religious identity. The self-meaning in that role will likely be different than the nurse who sees the role as one to enhance the role of spouse and a financial provider for the family in a health care business market; the role has no religious identity.

Self-identity is consistent with symbolic interactionism in that the nurse will construct an identity based on the meaning and importance of the nursing role (Blumer, 1969; Stryker, 1968). Symbolic interactionism and self-identity are the individual nurse's construction of reality based on the meaning that things have for the nurse. A nurse with a religious and moral identity to nursing will interpret nursing actions differently than the nurse with a financial identity to nursing.

Stryker (1980) emphasized that identities are hierarchically organized by "salience." Salience implies that the greater the prominence of an identity, the more motivated the individual will be to not only perform but to exceed in the role-related behaviors (McCall and Simmons, 1978). Such role-related behaviors of a professional nurse may be the involvement in state and national nursing organizations, such as the State Nurses Association or the American Nurses Association.

Some related concepts that fit with identity theory are commitment, interactions and social organization (La Rossa and Reitz, 1993). Commitment is an integral part of the self-identity. The degree of commitment accounts for the extent and quality of performances and is related to salience. For example, a nurse with commitment has regular time attendance on the job, serves on committees, and completes job assignments in a quality manner.

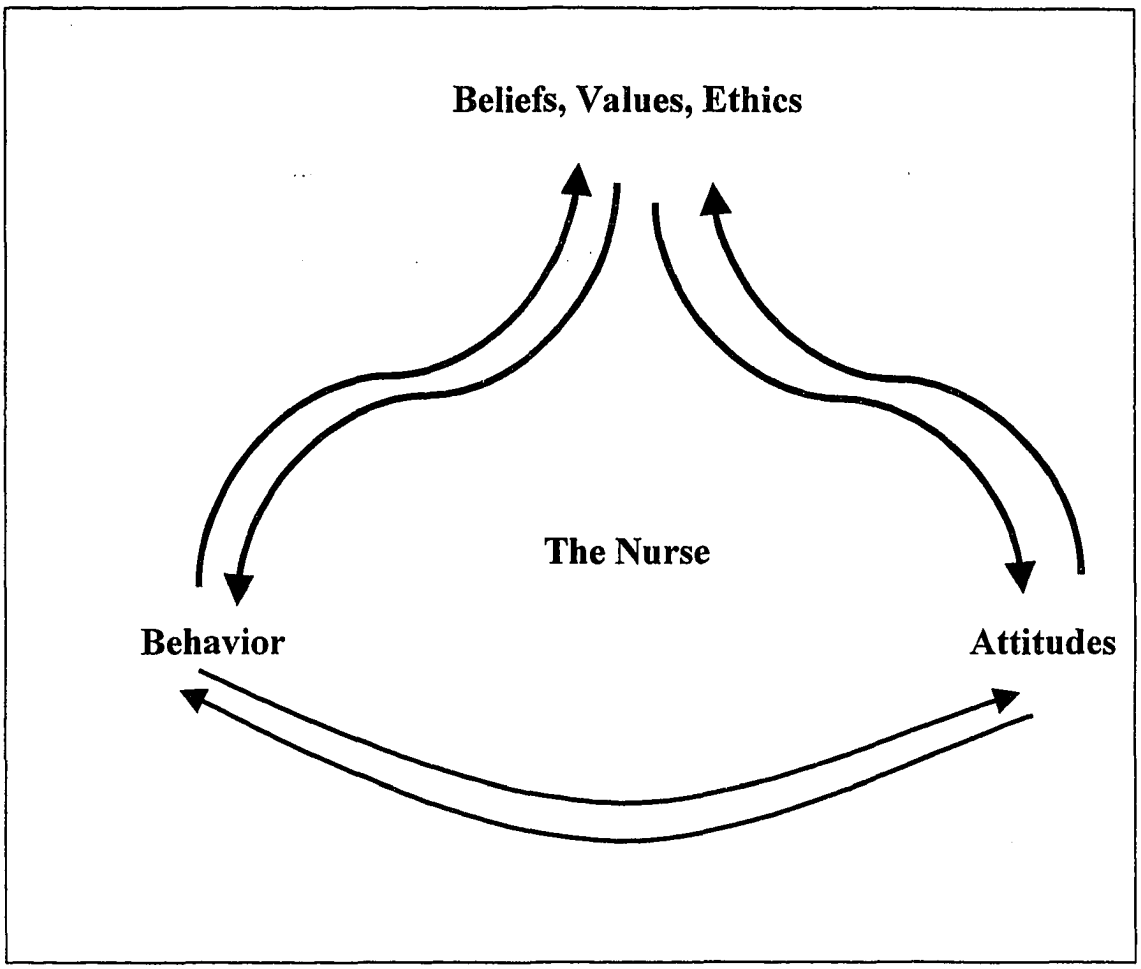
Self-identity is also displayed in one's interactions. Such interactions involve how one presents self to others. The presentation of self in everyday life (Goffman, 1959) entails using verbal and nonverbal clues to convey and announce who one is - the identity and the role of self. It is through social interactions that individuals share symbols and create meanings of self, others and situations (La Rossa and Reitz, 1993 p. 149). The presentation of self has an underlying moral character whereby the individual is expected to live up to his/her validated identity; if the individual lives up to the identity, society members are expected by society to respect that identity (Goffman, 1959 p. 176). Thus, a nurse is expected to maintain a therapeutic relationship with a patient if

societal respect is granted. The nurse's interactions and the identity of the nurse's role must be congruent with the symbols and expectations of society and the nurse must be ever mindful of such self-presentations.

The last concept, contexts, looks at how much behavior is shaped by culture and how culture is shaped by behavior (Stokes and Hewitt, 1976). This concept examines at the macrolevel the connection between the individual and society. Efforts have been made to delineate the connection between the individual and society through social organization. This concept will be explored from the individual nurse and the social organization of clinical settings. The nurse's perceptions of his/her role in the social organization (society and clinical settings) will serve to understand what significance contexts have on the nurse's behavior in the nurse-patient relationship.

The nurse is influenced by beliefs, values and ethics which shape the nurse's attitude and behaviors. Behaviors of the nurse are manifested through the attitudes, which in turn, are manifested through the nurses beliefs, values and ethics (see Figure 1.3).

Figure 1.3 Influences on the Nurse



Ethical Concepts

Ethics will be reviewed because it is important to understand what influence ethics plays in the nurse moving from a therapeutic helping role to a nontherapeutic relationship with a patient. The practice of nursing is laden with ethics, morals and codes of conduct to do what is right for patients. The very fiber of the nurse-patient therapeutic relationship is for the nurse to do right by the patient. Nursing history began with an ethical/moral beginning (Bandman and Bandman, 1994). Ethics in nursing is intertwined

closely with the symbolic interactionism theoretical perspective in that nursing was created symbolically in the ethical world and this ethical context has influenced nursing practice.

Ethics is a branch of philosophy that examines the questions of right and wrong or good and evil in human character or conduct (Silva, 1990). Ethics is concerned with doing good and avoiding harm. The practice of nursing, and nursing decisions, affect people. For instance, it is within the power of nurses to do good or to do harm to their patients (Bandman and Bandman, 1994). Contingent on whether nurses do good or do harm to patients depend on knowledge and values of the nurse. Both knowledge and values of the nurse have tremendous potential for doing good or harm and both have to be evaluated (Bandman and Bandman, 1994). The issues of what is good and what is harmful are focal areas in ethics.

In the practice of nursing, it is often not possible to do a patient good without causing pain. For example, passing tubes, injecting medications, or turning patients may be necessary for patient survival but inflicting pain in the process is required. Another example of causing harm but from an undesirable ethical perspective is when a nurse withholds information and counseling that is needed by a patient because the nurse does not agree with the situation. For instance, if the values of the nurse are to avoid abortions, the nurse may withhold information about abortions from the patient.

The ethics of caring is frequently addressed in nursing literature (Bandman and Bandman, 1994; Benner and Wrubel, 1989; Curtin, 1979; Sarvimäki, 1988; Silva, 1990).

Caring is a theory of morality; it is a form of doing good and avoiding harm and is central to nursing ethics (Bandman and Bandman, 1994). To Benner and Wrubel (1989), caring means that people, events and things matter to people- it means being involved. Caring means commitment. A process whereby commitment is expressed is through the role of being a patient advocate.

Bandman and Bandman (1994) emphasized that advocacy is important because rights are protected through advocacy. There are no rights without advocacy. Nurses are often in a position to defend patient rights in situations where the patient is unable or incompetent to stand up for their rights. Such patient populations include the frail elderly, the infant or the mentally ill. Additionally, nurses struggle against the cost-containment authorities in health care systems when patient safety is jeopardized with reducing staffing levels to substandard proportions. Nurses are confronted with nursing dilemmas frequently in practice.

Effective nurses function as moral agents (Bandman and Bandman, 1994) to ensure that good is done and harm is avoided. The profession of nursing has expressed moral values in the *Code for Nurses (1985)* with the statement of policies and decisions to be made by nurses in clinical practice. The *Code for Nurses* (1985) expresses a moral commitment for nurses to uphold. It encompasses the protection, promotion, and restoration of health; the prevention of illness and the alleviation of suffering. A fundamental message in the code is respect for the rights and dignity of others.

Synthesis

The contextual world view, the world view of this investigator, is a way to conceptualize reality. The reality is a dialectical process; there is a logical argumentation to understand the reality in any given situation. The contextual world view acknowledges that reality is dynamic, changing but events are interconnected. The dialectical process of the contextual world view is enhanced by the symbolic interactionism theoretical perspective. Symbolic interactionism helps explain and understand society and humans interacting in society. It provides a frame of reference for understanding how human beings create symbolic world and how these symbolic worlds shape human behavior.

Summary of Chapter One

The first chapter provided an introduction to the importance of the nurse-patient relationship, background information and addressed the research problem as well as related issues and their magnitude. The significance of the study for the profession of nursing was addressed. The theoretical perspective for the study was discussed. Chapter one concluded with the contextual world view, symbolic interactionism and identity theories and other related concepts. The following chapter presents the review of related literature.

CHAPTER TWO

REVIEW OF THE LITERATURE

The theoretical framework, explicated in Chapter One, provided an initial orienting framework for the literature review. The literature review presented in Chapter Two is the result of an extensive search of theoretical and empirical data to enhance the perspective of the substantative area of inquiry. The search included related extant conceptualizations of staff-patient relationships across disciplines. Staff in this context refers to health care professionals.

Four headings are presented to organize the literature review data. For heuristic purposes, they are presented in the following order: Practice Issues, Ethical Issues, Legal Issues and Educational Issues.

Practice Issues

Patients, as consumers of health care, are protected by state and federal laws, nurse practice acts and codes of conduct. Nurses are held accountable from legal perspectives to render patient care in a competent manner as defined by nurse practice acts, to conduct nursing practice in an ethical and moral fashion as outlined in code for nurses. To ensure that nurses adhere to such practice standards, State Boards of Nursing, the licensing authorities, serve to monitor any infractions of practice and prosecute accordingly.

The Hippocratic Oath clearly states that ethics is a factor. "In every house where I come, I will enter only for the good of my patients, keeping myself from all intentional ill-doing and seduction, and especially from the pleasures of love with women and men."

(Dorland's Medical Dictionary 1974, p. 715).

Individuals in American society are taught from childhood to respect, admire, and obey professional staff (Peterson, 1992). Society's members have had repetitive social conditioning to reinforce this message. For example, individuals take foul-tasting medicine, receive painful injections, endure uncomfortable procedures and readily expose the body upon request to nurses and doctors. Professional staff have special knowledge and have codes of ethics to guide practice. Each discipline's code of ethics is written to capture the respect of individual members of society. The Hippocratic Oath is more than 2400 years old and clearly says the practitioner is to do good and avoid all intentional ill-doing. Professional organizations (American Nurses Association, American Medical Association, American Psychological Association, National Association of Social Workers, American Association of Marriage and Family Therapy) endorse the ethical practice of doing good and avoiding harm. Therapeutic staff-patient relationships is an essential element for each discipline.

The review of literature across disciplines in the context of maintaining therapeutic staff-patient relationships revealed practice issues of power, self-disclosure, gifts and sex as the most salient issues. Each issue will be presented.

Power

In staff-patient relationships, there is a power imbalance; it is not an egalitarian relationship. Therapeutic staff-patient relationship is based on unequal power and unequal responsibility. Each discipline acknowledged this power imbalance, and

proclaimed it to be the responsibility and duty of staff to respect the power base given to the professional (Kutchins, 1991).

Staff clearly have more power than patients, yet most staff do not feel all that powerful (Peterson, 1992). Staff have expert knowledge and patients have a need. This imbalance in power puts the patient in a vulnerable relationship to the staff. This is where the profession provides written policies and codes that enumerate the boundaries of professional/ethical conduct with patients (Peterson, 1992). The general intent of codes is to protect the patient and prevent staff from abusing their power. Staff power to hurt or harm is the dark side of staff power to heal (Sherman, 1993). It is the responsibility of staff to guide the therapeutic process in the staff-patient relationship. In conclusion, staff must act responsibly with the power granted to them by society. Power can be used for healing or for hurt.

Self-disclosure

The literature, across disciplines, addressed self-disclosure of personal information by staff as tantamount to more serious exploitations of the staff-patient relationships (Anderson and Mandell, 1989; Epstein and Simon, 1990; Greenspan, 1986; Gutheil and Gabbard, 1993; Reisman, 1986; Rothman, 1989).

The issue of self-disclosure is labeled as a minor boundary violation of the therapeutic relationship but often shows a crescendo pattern of increasing intrusion into the patient's space (Gutheil and Gabbard, 1993). It is termed the "slippery slope" (Gutheil and Gabbard, 1993) and is the characteristic scenario. Gabbard (1989) defined a

sequence of self-disclosure that is quite subtle: transitioning from last-name to first name; then sharing some personal information that progressively intrudes into the clinical role.

Sometimes staff use self-disclosure techniques to reduce the power imbalance in the staff-patient relationship; this is a false assumption by staff that they are engaged in a truly egalitarian partnership (Rothman, 1989). The use of self-disclosure by staff inappropriately shifts the focus from the patient to the staff and to the staff's needs (Anderson and Mandell, 1989; Greenspan, 1986). Staff should carefully self-scrutinize the self-motivation behind any form of self-disclosure - even mild forms (Gutheil and Gabbard, 1993). Staff are advised to look at unfulfilled needs in their private lives when tempted to disclose personal information (Anderson and Mandell, 1989; Epstein and Simon, 1990; Greenspan, 1986; Gutheil and Gabbard, 1993; Rothman, 1989).

Gifts and Rewards

Often staff-patient relationship and boundary issues arise at the interface between good manners and therapeutic relationships/techniques (Gutheil and Gabbard, 1993). For example, an appropriate response in social convention is for staff to offer a tissue to a crying patient. Flowers and cards may be appropriate expressions of condolence to the bereaved in certain contexts. Whether to offer a patient coffee often seems in order in many situations. When the patient responds to the offered coffee by bringing in donuts at the next visit, then it poses a dilemma. The psychodynamics operating behind gift-giving are difficult to understand. Gifts are given as sincere appreciation of service, as bribes to

get needs met, as payment when one feels undeserving of service and lastly, as reciprocation of some good deed or service rendered (Gafner and Trudeau, 1990).

Gifts have posed one of the most conflicting and problematic areas in staff-patient relationships (Gafner and Trudeau, 1990). Some clinical examples of giving/receiving gifts are offered from experiences of the Tucson VA Medical Center Boundaries Team (Gafner, 1986-2002). The Boundaries Team learned that a patient's wife complained to the CEO that her husband was not getting the same quality of care as the roommate. The roommate's wife brought in donuts each morning for the nurses to enjoy with their coffee. Another patient donated a television to the psychiatric unit. Each time the patient was admitted to the unit, he wanted to dictate which programs the group would watch on "his" television.

Another example involved a former patient with mechanical skills, temporarily unemployed, who did some extensive car repairs on the nurse's automobile. The nurse paid the patient a substantial sum for the repairs but found the car still malfunctioned. The patient was readmitted to the nurse's unit. The nurse wanted the patient-mechanic to make good the services he had charged her for on her car. In another situation, a nurse gave a patient a ride to his home as he lived within route to her home. They were in an automobile accident and the patient suffered a whiplash. He filed a lawsuit against the nurse. The questions become: Who was the victim and who was the perpetrator in each case? Did the good intentions of the nurse justify the outcomes?

Sex

In a crescendo pattern of increasing intrusion into the patient's space from minor intrusions initially, sexual relationships between staff and patients are listed as the most extreme exploitation of the therapeutic relationship. Sex between staff and patient is specifically forbidden by the Hippocratic oath and the ethics codes of most disciplines.

Most of the literature that was reviewed addressed sexual intimacy issues as being unacceptable by the profession (American Psychiatric Association; American Psychological Association; National Association of Social Workers; National Council for State Boards of Nursing). However, the problem of sexual intimacy between staff and patient is far from rare. Male psychiatrists surveyed showed that 10 percent had engaged in erotic practices with their patients (Kardner, Fuller and Mensh, 1973). They found 5 percent admitted to sexual intercourse with their patients. Psychologists surveyed in a sample of 1000 (500 men, 500 women) by Holroyd and Brodsky (1977) found that 10.9 percent of male psychologists acknowledged having erotic contact with patients and 5.5 percent admitted to sexual intercourse; only 1.9% female psychologists admitted to sexual intercourse with patients.

Gartrell, et al. (1986) determined that 6.4 percent of all psychiatrists respondents, 7.1 percent of the men and 3.1 percent of the women, had had sexual contact with patients. Kluft (1989) stated that even more appalling statistics are likely as the nonrespondents to such surveys are probably respondents who are not acknowledging such egregious behaviors, even with anonymous questionnaires. Gartrell (1986) later

learned that 65 percent of therapists said they had treated patients who had been sexually involved with previous therapists. Only 8 percent had reported the incidents to authorities, yet all stated the encounters had been harmful to them. Psychologist Gary Schoener (1992) of the Minneapolis Walk-In Counseling Clinic has consulted in more than 2,000 cases of therapist-patient sex.

Social workers, along with psychiatrists and psychologists, in another study (Borys and Pope, 1989) revealed that from a total of 4,800 of the three disciplines it was found that each profession had equal rates of sexual involvement with patients.

Nurses have not typically been included in such surveys. A study conducted by two nurses (Munsat and Riordan, 1990) looked at sexual interactions between staff and patients on inpatient units of 169 hospitals. The results were not reported specific to disciplines but rather to type of outcomes. Of the 169 hospitals, 23 percent reported suspicions of sexual interactions, 43 percent reported allegations and 23 percent reported actual occurrences of sexual interaction between staff and patients.

The National Council of State Boards of Nursing, Inc. (1995) issued a report of nurses reported as having sexual misconduct between March 1, 1994 and March 31, 1995, was 43 cases (23 RN, 20 LPN) with a small percentage (0.6 percent) of the 6, 931 total cases reported. The Council took the position that even one case is serious and initiated proactive education action.

Some studies have noted a difference in gender as related to violations. Most therapists (staff) are men (80-10%) and most patients (90%) are women (Bouhourtsos,

Holroyd, Lerman, Forer and Greenberg, 1983; Herman, Gartrell, Olarte, Feldstein, Localio 1987; Kluft, 1989; Sherman, 1993). Women are less likely to engage in boundary movings (nonsexual) such as nonclinical business transactions, and breaches of confidentiality as reported in a national survey of psychiatrists, psychologists and social workers (Borys and Pope, 1989). Female staff who became sexually involved with patients did so in an effort to "rescue" the patient from their despair/turmoil by healing the patient with love (Averill, et al., 1989; Collins, 1989).

Gartell, Herman, Olarte, Feldstein and Localio (1986) found that adverse modeling of therapists supervisors, such as having sex between student-supervisor, played a major role in whether the staff would later engage in sex with patients. They also found that staff were quite capable of gross denial by rationalizing the sexual conduct with patients as beneficial. A high incidence (5-10%) of sexual contact between educators and students in mental health training programs was found (Gartrell, et al., 1989; Pope, Levenson, and Schover, 1979).

In summary, the most extreme violation of the staff-patient relationship, and the most frequently studied, is sex between staff and patient. Sex does not occur as a direct shift from talking to intercourse; the "slippery slope" is the characteristic pattern (Gabbard, 1989; Guthiel and Gabbard, 1993; Simon, 1989). There is usually a transition from minor boundary moving to the extreme sexual misconduct violations.

Ethical Issues

Nurses, as well as other health care staff, are society's anointed and trusted health care servants. There are spiritual and ethical dimensions interwoven in the history of nursing. A persistent thread throughout nursing history is the nurture and care of human beings by nurses, regardless of socioeconomic status, race, religion, cultures, or the nature of the health problem (Benner and Wrubel 1989). For example, nurses cared for lepers then and HIV/AIDS patient today. Both populations have been the rejects of society. This is about doing good and preventing harm; historically that is what nurses have done. The pay off or the return outcome for the profession of nursing is that society recognizes and gives power to profession of nursing; society trusts the profession's members to do good and prevent harm. But can every nurse be trusted to do what is good and prevent harm to the patient?

Bandman and Bandman (1994) pose the ethical questions of what is good or harm? What is good for whom? What is harmful to whom? This is where nursing ethics and the *Code for Nurses* provide individual nurses with guidance in ethical and moral reasoning. The *Code for Nurses,* a code of ethics, explicates the primary goals and values of the nursing profession. It states the moral principles that "prescribe and justify nursing actions" (American Nurses Association, 1985). The *Code* provides a document to society to state that nurses are expected to understand and accept the trust and responsibility invested in them by the public (Bandman and Bandman, 1994). The *Code* provides the

important element for the nurse-patient relationship by stating what is professional conduct and appropriate nurse-patient relationships.

The relationship of the nurse to the patient is one of being a patient advocate (American Nurses Association, 1985). The role of advocate is defined as being committed to the patient's care and safety. The patient is placed at the center of rational decisions. The principles of beneficence (doing good), nonmaleficence (avoiding harm), veracity (truth-telling), confidentiality (respecting privileged information), fidelity (keeping promises), and justice (treating people fairly) are basic/fundamental values of respect inherent in the *Code* (Bandman and Bandman, 1994). The *Code for Nurses* is a statutory force with sanctions that can be instituted to enforce the provisions. The regulating function of the Code is to influence standards and the practice of nursing in effort to provide safe, quality care to patients. It also protects the nurse by defining what is safe, competent and moral nursing care.

The theories of ethics in nursing are too extensive to include in this paper. The decisions that nurses make each day influence patient health outcomes, and are often decisions that require some ethical reflection. Some examples include forced treatment (given without the consent of the patient or even with their objection), rendering expensive life-saving measure to encephalic babies who are never going to recover, giving advice/education to patients seeking hopeless alternatives for terminal diseases and participating in abortions. Nurses may also be faced with violations of the staff-patient relationship as evidenced by behaviors of a co-worker. For instance, perhaps sexual

intimacy or financial exploitation of the nurse with the patient is suspected. What ethical responsibilities does the nurse have in reporting the suspected behaviors? The *Code for Nurses* defines the responsibilities.

In summary, nurses are confronted with ethical issues in the practice of nursing everyday. The subtle issue of the nurse-patient relationship and the ethical parameters are often seen as less complex until it reaches the degree of exploitation. The ethical reflections by the nurse, as well as the ethical standards inherent in the *Code for Nurses*, are important guidelines for the nurse to use in professional practice in a therapeutic relationship with the patient.

Legal Issues

Increased complaints and lawsuit against staff, including nurses, for moving out of the therapeutic zone into exploitative relationships with patients have lead to the creation of state task forces (Coleman and Schaefer, 1986). The task forces have, in turn, encouraged legislation which prohibits sexual contact between staff and patients, as well as legislation to govern specific behaviors of staff (Coleman and Schaefer, 1986).

In 1984, the Minnesota state legislature enacted a task force to investigate complaints of sexual exploitation by therapists after many complaints were filed by victims. The result was that several bills were passed which currently make it a felony for staff to have sex with a patient while in treatment (Sherman, 1993). Wisconsin enacted a new law in 1984 to make it a crime (Class A misdemeanor) for staff to engage in sexual misconduct with the patient in treatment. Nine states now classify sex with

patients as a felony: Minnesota, Wisconsin, North Dakota, Colorado, California, Main, Florida, Iowa and Georgia (Sherman, 1993). These states have enacted penalties that include serious prison time. In all 50 states, the patient may sue staff under common law for battery or malpractice (Jorgenson, Randles and Strasburger, 1991).

Additionally, it was found that all psychiatric patients being sexually abused by any staff were a major concern for all health care professionals. The American Psychiatric Association and the American Psychological Association now discuss the issue regularly at their annual meetings (Laury, 1992). Licensure Boards of all professionals rely heavily on existing codes of professional ethics (Schoener, Milgrom, Gonsiorek, Leupker and Conroe, 1989). They also rely on professionals to report violators. The reporting of staff violations has improved but is still under-reported and as little as 1-2% are brought to the licensure board attention (Davidson, 1977; Munsat and Riordan, 1990; Pope, Keith-Spiegel and Tabachnick, 1987; Schoener, et al.,1989; Vinson, 1984).

No one knows how many victims of staff-patient relationship exploitation there are. There needs to be greater accountability and policing by members in each discipline. It is the lack of disciplinary action by each profession that leads to other interventions, and ultimately to legislative intervention. Self-help and consumer groups have proliferated, as identified by Schoener and Gonisiorek (1988). Advice columns such as "Dear Abby" and "Dear Ann Landers" and consumer-oriented articles in publications such as Newsweek, U.S. News and World Report, New York Times, Savvy, and Glamour

are examples. These articles address unethical practices of therapists with patients and are accompanied by guidance tips for patients. Self-help and consumer groups have evolved sequentially, as listed: Association of Psychologically Abuse Patients - Sylvia Diamond (1982); National Committee for Preventing Psychotherapy Abuse - Bill Cliadakis (1982); Stop Abuse by Counselors - Shirley Siegel (1983); Consumers Against Psychotherapy Abuse - Peggy Black (1985); Consumers Against Sexual Exploitation - Jane Rasmussen (1985); I.M.P.A.C.T. (In Motion - People Abused in Counseling and Therapy) founded by three victims in Colorado (1988); Good Tidings - A Support Group for Women (1984); and Advocates for Responsible Therapy - Linda Gifford (1989).

Such groups precede legislation when public demands soar asking for consumer protection. Some categories of offenders are best controlled through criminalization of exploitative acts (Coleman and Schaefer, 1986; Schoener and Gonisiorek, 1988). Despite licensure boards, legislation and professional codes of ethics, lawsuits are on the increase for staff-patient relationship violations. Licensure boards must have such behaviors reported in order to seek disciplinary action. Unfortunately, boundary violations are under reported. In turn, victim groups have increased to educate the consumer. Such victim groups have historically lead to stronger legislative action in an effort to protect consumers.

Gary Schoener, Executive Director of the Minneapolis Walk-In Counseling Center, said many staff who were repeat offenders of sexual misconduct, stopped the behavior when it became criminalized. The strength of making the offense a crime is that

it stops the offender from being able to practice but the downside is that it makes it more difficult for the abused patient to collect insurance compensation. Most malpractice insurance companies exclude criminal activity from compensation so criminalization of the offending staff also hurts the victim patient.

Insurance companies are concerned with staff-patient relationships and sexual conduct of staff. According to one insurance claims representative (Burick, 1985) in an interview with Coleman and Schaefer (1986), insurance claims filed for sexual misconduct in Texas are second only to fee-dispute claims. Malpractice suits handled through the American Psychological Association insurance show 1 out of every 10 suits involve sexual misconduct (Pope, Keith-Spiegel and Tabachnick, 1986). Some insurance companies have declined coverage for psychologists because of increased complaints of sexual intimacy between staff-patient (Pope, et al., 1986). Sexually abused patients are learning to sue their therapists and are being awarded substantial sums of money. Malpractice insurance premiums have increased as a result of this trend.

In California, 56% of the disciplinary actions taken by the Psychology Examining Committee (Vinson, 1984) are for sexual abuse cases. It is a concern to be dealing with such significant numbers of staff-patient sexual abuse cases. Of even greater concern are the surveys which show that sexual misconduct cases by staff reflect a difference in their attitudes; these staff are unable to recognize the harmfulness of their behaviors. In fact, a number of them espouse an "underground" belief in the therapeutic benefits of sexual contact with patients (Herman, et al., 1987; Vinson, 1984).

In such cases, it becomes a question of education/rehabilitation or go straight to criminalization to stop the offenses. Criminalization represents one end of the spectrum of possible sanctions for sexual misconduct between staff and patient (Appelbaum and Jorgenson, 1991).

In summary, despite licensure boards, legislation and professional practice standards and codes of ethics, lawsuits are on the increase for staff-patient relationship violations. The cyclical pattern is that licensure boards must have behaviors reported in order to seek disciplinary action. Boundary violations are underreported. Subsequently, victim groups increase to educate the consumer. The outcome is that concerned consumer groups have historically lead to strong legislative action and this process will likely continue if staff (nurses) move from the nurse patient therapeutic relationship into boundary violations.

Educational Issues

Education of health care professionals in the importance of maintaining a therapeutic staff-patient relationship was clearly evident across disciplines (American Nurses Association, American Medical Association, American Psychological Association, National Association of Social Workers). Staff-patient relationships, in particular the therapeutic elements of a staff-patient relationship, are valued as an educational component of all professional disciplines. In nursing, the therapeutic use of self by the nurse in directing the patient toward health is well-established (Peplau, 1969; Lego, 1980). Self-awareness and self-assessments scales to determine professional

closeness by the nurse has been used extensively (Pennington, et al., 1993; Pilette, Berck and Archber, 1995; Sabey and Gafner, 1996; Smith, Taylor, Keys and Gornto, 1997). Peplau (1969) assumed that professional closeness, the complex patterns of nurse-patient relationships, are taught in a professional school.

In addition to basic nursing education, many workshops, programs and seminars are being conducted in nursing throughout the U.S. to prevent boundary violations, (Dillon, 2000; Gafner, 1986 - 2002) enhance awareness in nurse-patient relationships and to rehabilitate (to a limited extent) the nurses who have had boundary violations. Most of these programs include some background information of nurses at risk for leaving the therapeutic zone of helpfulness and entering into an exploitative relationship with the patient. All nurses in the clinical settings are exposed to the subtleties and ambiguities in the nurse-patient relationship. Nurses are most often guided by good intentions rather than by the facility policies, the professional code of ethics, or the standards of practice (Pennington, et al., 1993). Good intentions, unfortunately, are not always enough to keep the nurse in the therapeutic zone of helpfulness. Supervision, peer review/feedback and open discussions about those areas in the nurse-patient relationship that may allow the nurse to get in over his/her head can be vital in prevention (Sabey and Gafner, 1996). Such areas include identification of nontherapeutic self-disclosure by the nurse, sexual attraction to a patient, dealing with gifts, identifying and separating personal goals from professional goals.

It is recommended that education include a review of professional codes of ethical conduct. However, education does not solve all nurse-patient relationship problems because some staff are not material for rehabilitation. Schoener (1992) identified categories of boundary violators according to personality disorders who do not quality for rehabilitation. There are many disciplines that encourage staff providing therapy to patients to be involved in counseling themselves, particularly if they are going through periods of vulnerability (Coleman and Schaefer, 1986).

Education is strongly recommended across all disciplines. To avoid serious boundary violations, exploitation scales/instruments have been developed to assist staff in self-monitoring (Epstein and Simon, 1990), because it is evident that some calculating, predatory staff will deliberately exploit vulnerable patients (Gabbard, 1993, in an interview).

Regardless of the education program of staff, there are exploitative behaviors that every staff should know are ethically wrong. All professions are in unambiguous agreement on this point (American Association for Marriage and Family Therapy, National Association of Social Workers, American Nurses Association, American Psychiatric Association and American Psychological Association).

The impact of education on affecting attitudes of staff was not addressed explicitly in surveys of staff engaging in exploitative (sexual) behaviors with patients (Herman, et al., 1987). However, education, in the context of altering attitudes, may have some potential. One noted expert in attitudes and attitude changes (Triandis, 1969; 1980)

in social behaviors identified that attitudes can be changed in a variety of ways. He listed four ways, which are briefly described, for heuretic purposes: First, new information from other people or through mass media may produce a change through the cognitive functioning first, then the attitude. Second, direct experiences (an affective component), which cause some dissonance between the person's cognition's, may change an attitude. An example would be an intense dislike for a particular ethnic group but a pleasant encounter with one person of the ethnic group disliked can alter the attitude. The same could be true with the direct experience of a stern disciplinary Board action for a staff violator of sexual conduct with a patient. Third, force laws to change unacceptable behaviors by enacting legislation to make it a crime to sexually exploit patient. And finally, "Fail - Accompli" or once an event has taken place, attitudes change to become consistent with the implications of the event. For example, a victim and members of society will likely endorse the penalties imposed on health care providers when sentenced to prison for violating the staff-patient therapeutic relationship. Following the final sentence, there is a tendency for the cognitive component of attitudes to become consistent with the legal action. The model from Triandis (1969; 1980) provides hope for educating/rehabilitating staff.

In summary, despite licensure boards, legislation and professional codes of ethics, lawsuits are on the increase for staff-patient relationship violations. Licensure boards must have exploitative behaviors reported in order to seek disciplinary action. It is advocated that staff education is needed along with rehabilitation programs.

Summary of Chapter Two

This chapter provided a review of the literature under four predominate issue headings: Practice Issues, Ethical Issues, Legal Issues and Educational Issues. In clinical practice, the predominate theme was that staff have power over the patient which is to be respected and used for therapeutic purposes for the patient; staff are to be aware and limit self-disclosure of personal, information as this is often a subtle and progressive digression in leading to a boundary violation, the serious one being sexual exploitation of the patient. Ethical issues were presented, in a brief context, to trace the history and practice of nursing built on the ethics principle of doing good and avoiding harm to the patient. Nursing is a caring profession based on moral practice. The legal perspective of staff-patient therapeutic relationship was emphatic in that legislative measures have been enacted to protect patients from staff who engage in exploitative relationship with the patients. Lastly, educational issues were addressed from the framework that all professional disciplines advocate staff education in the guiding principles that facilitate adherence to maintaining therapeutic staff-patient relationships. In Chapter Three the methodology is presented.

CHAPTER THREE

METHODOLOGY

This chapter describes the methodology used in this study. It is organized into three sections: background on grounded theory, a description of the procedures, and data quality. The background section will include a discussion of the usefulness of the grounded theory method for elucidating the nursing phenomena with a symbolic interactionism theoretical perspective and the grounded theory process. The section on procedures will include: maintenance of theoretical sensitivity, ongoing literature review, theoretical sampling, data collection procedures, and data analysis. The third section, data quality, will address the criteria for trustworthiness in this grounded theory study.

Background on Grounded Theory

The grounded theory methodology was used to answer the research questions posed in this study. The inquiry that the research questions sought to answer, the epistemology embodied in understanding what the researcher wanted to know, lead to qualitative research methodology of grounded theory. Grounded theory is a general methodology, a way of thinking about and conceptualizing data. It is to develop theory from data that is grounded - generated and developed through interplay with data conducted during the research process (Glasser and Strauss, 1967; Strauss and Corbin, 1990). It is predominately an inductive methodology and is designed to discover basic patterns of social and psychological life. It is a process of inductive theory building based squarely on observations of the data about a phenomena (Crotty, 1998).

Symbolic interactionism, as discussed in Chapter One, is a theoretical perspective for the grounded theory methodology. Symbolic interactionism serves as a frame of reference for understanding how humans create symbolic worlds and how these worlds shape behavior. The discipline of nursing has supported the use of grounded theory methodology in research as evidenced by citations in nursing research literature (Atwood and Hinds, 1986; Munhall, 1982; Simms, 1981; Stern, 1980; Chenitz, and Swanson, 1986). The grounded theory methodology is congruent with nursing philosophy for theory development in solving clinical problems (Chenitz and Swanson, 1986). The usefulness of the grounded theory methodology is that it is designed to guide researchers in producing theory that is rich with conceptual relationships. These theoretical conceptualizations and relationships means the researcher is pursuing patterns of action and interactions between and among various social units where little information is known. The psychological and social processes of the nurse-patient relationship are such social units for theory development and was the goal of this study. If there is to be an understanding of why any nurse leaves the therapeutic realm of the nurse-patient relationship to engage in any type of exploitative or nontherapeutic relationship with a patient, the questions must be asked of nurses who have experienced the phenomena. This area of inquiry builds upon nursing theorists metaparadigms (e.g., Peplau) that speak to the importance of the nurse-patient relationship.

The Grounded Theory Process

The grounded theory methodology utilized in this study sought to ensure that theory emerged from the data rather than from some other sources. The theory evolved through a continuous interplay between data collection and data analysis (Glasser and Strauss, 1967). The specific process of grounded theory method involves the following steps: 1) simultaneous data collection, coding, analysis, and categorization, 2) development and integration of categories using the constant comparative method, 3) data reduction, theoretical sampling, and identifying core categories, and 4) theory construction (Glaser, 1978). First, in grounded theory, data is simultaneously collected and analyzed using the constant comparative method. The constant comparative method combines the joint coding and analysis of the data to generate theory. It is concerned with generating many categories, properties and hypotheses about a general problem. The properties generated using the constant comparative method may be causes, conditions, consequences, dimensions, types and processes. The properties generated should result in an integrated theory at the end of the process (Glaser and Strauss, 1967). The four stages of constant comparative method are described briefly: 1) comparing incidents applicable to each category 2) integrating categories and their properties 3) delimiting the theory and 4) writing the theory (Glaser and Strauss, 1967, p. 105). The constant comparative analysis involves a constant comparison of events incident to incident, for the purpose of establishing underlying uniformity or any varying conditions of the uniformity. After comparison of incident to incident and establishing uniformity of

conditions, the incidents are then compared to concepts to generate new theoretical properties of the concept and new hypotheses. While comparisons of incident to incident and incidents to concepts are continued, concepts are compared to concepts for the purpose of establishing the best fit with a set of indicators. Theory should fit the data: categories, properties and concepts should not be made based on forced fit, pre-selected or pre-conceived ideas with subsequent selection of data. Constant comparison of data generate categories that explain what happened and what is relevant.

Essentially the qualitative interviews are broken into data bits and labeled with all possible categorical names. As properties of each category are identified from the data, more information on the nature of the category are refined and enriched. The categories are referred to as a "slice of data" (Glaser and Strauss, 1967, p. 193). The categories and their properties are the elements of a grounded theory that have explanatory power. The data is then reduced to a category that is a conceptualization of many indicators of behavior under one idea that denotes an underlying pattern. A property is a conceptual aspect or element of a category which denotes the nature of a category. Both categories and properties are concepts indicated by the data (Glaser and Strauss, 1967).

Finally, a core category emerges and accounts for most of the variation in a pattern of behavior. Core categories tend to recur frequently in the data, and take more time to saturate because they are related to so many other categories. Theory is generated around a core category. The generated theory should account for a pattern of behavior that is relevant and problematic for those involved. A Basic Social Process is one type of

core category and represents a process or something which occurs over time and involves change over time. Glaser (1978) described the process as having "grab" in that the researcher tends to see the core category in all relationships. Core categories can be a process, a condition, a consequence or a dimension (Glaser, 1978).

Glaser (1978) described two types of basic social processes (BSPs), basic social psychological process (BSPP) and basic social structural process (BSSP). A basic social psychological process refers to a basic psychological process, such as identification of being a nurse. A basic social structural process represents growth (or deterioration). The basic social structural process is often helpful in explaining what conditions, over time, were changed. For example, policy implementation of rules of conduct for nurses not to accept gifts from patients may facilitate the basic social psychological process of the nurse maintaining nurse-patient boundaries in this area. A basic social process is not always present in grounded theory as is the case for core categories. A core category is always present in grounded theory. When a basic social process is discovered, it is usually processed out into stages that transpire over time. The idea of change is inherent in the basic social process so that, over time, new conditions, stages and transitions can be added. Grounded theory research method is a systematic approach, predominately an inductive method, designed to discover basic patterns of social life. Theory emerges from the data and the observations made by the researcher.

Theoretical sensitivity is deemed as an essential task throughout the inquiry. Theoretical sensitivity is a term coined by Glaser and Strauss (1967) to address a personal

quality of the researcher. It refers to the researcher's capacity to have awareness of the subtleties of the data and to give meaning to the data. In any research situation, the researcher comes with varying degrees of sensitivity. The researcher's insight, the ability to give meaning to data, the capacity to understand, and the ability to separate the relevant from the irrelevant is what theoretical sensitivity addresses.

The maintenance of theoretical sensitivity is an essential and challenging task for any researcher. In each stage of grounded theory, there are techniques built into the process to encourage creativity (Glaser, 1978; Glasser, 1992). Throughout the research process, writing memos encourages the researcher to do some introspective reflective thinking at each stage. It helps the researcher to remain receptive to emerging theory with an open mind. Preconceived ideas are addressed but in the context of using these ideas as data so the researcher can remain as unbiased as possible. It is helpful to minimize the literature review prior to beginning the research in order to remain unbiased in generating categories and theoretical codes that emerge from the data.

Theoretical sampling is the unique sampling procedure in grounded theory. It is a process of data collection for the purpose of generating theory, while simultaneously collecting, coding, analyzing the data, and deciding what data to collect during the course of inquiry. The emerging theory is used to generate questions (working hypotheses) which then specify further sampling decisions. Sampling decisions are made as deemed relevant to the emerging theory. Data are coded using the constant comparative method. Data are analyzed initially line by line and later selectively sampled to further develop the

core concepts. Theory is then constructed around a core category (Glaser, 1978). The codes that emerge are developed theoretically until saturation occurs. This means no new concepts emerge from the data (Glaser, 1978).

Description of Procedures

The grounded theory methodology has several procedural components that occur simultaneously. The discussion of procedures in this chapter does not attempt to order the procedures sequentially. For the purpose of explanation of procedures, the discussion is organized into five headings: maintenance of theoretical sensitivity, ongoing literature review, theoretical sampling, data collection, data management procedures and data analysis.

Maintenance of Theoretical Sensitivity

Theoretical sensitivity in the grounded theory methodology is the ability of the researcher to remain open to the data (Glaser, 1978). It refers to the researcher's capacity to have awareness of the subtleties of the data and to give meaning to the data. In this research situation, the researcher came with varying degrees of sensitivity. For example, the researcher had been a middle manager in nursing for thirty years and has experience with nurses violating the nurse-patient relationship. The researcher had also participated in presenting educational conferences on the topic. The biases, assumptions, patterns of thinking and knowledge of the researcher were addressed. These experiences were acknowledged through early discussions with the primary faculty advisor to decrease the researcher's reactivity during the study. The recommended techniques to enhance

theoretical sensitivity by Strauss and Corbin (1990) were used. These techniques included questioning, looking and thinking of potential categories and their properties and dimensions when examining the data. The second technique involved analyzing words, phrases, sentences and flip-flopping procedures (looking at the opposite concept). The third technique, comparing phenomena, was used. The maintenance of theoretical sensitivity was achieved but was a challenging task for this researcher in the early stages.

Ongoing Literature Review

It is recommended that literature reviews occur after the data has been collected in grounded theory research. The literature review was conducted early (1996-1997) in the process and was set aside until after data was collected and analyzed. Data was collected and when the theory appeared developed and grounded, then the literature was reviewed again to integrate concepts from the literature into the theory (Glaser, 1978). The rationale for this approach was to permit the researcher to initially approach the area of inquiry *tabula rosa* with an open mind to emerging concepts. However, it was necessary to conduct an initial literature review for this study for theoretical context of what had been theorized, studied or written, and what were the concepts related to the phenomena of interest. Literature from all disciplines was reviewed as it related to the substantive area. The literature review helped to focus the path of inquiry for the researcher. Following data analysis, and development of a theoretical framework, the literature review was resumed. The literature review was compared to the research findings to generate more ideas for theory development of the emerging theory (Glaser, 1978).

Theoretical Sampling

The sampling procedures for grounded theory methodology are purposeful; the sampling decisions are based on the researcher's efforts to saturate categories, properties, and interrelationships. It is called theoretical sampling because the emerging theory is used to generate questions. Progressive sampling decisions are made as deemed relevant to the emerging theory.

To illuminate the processes involved in this study, registered nurses who had personal or experiences as a co-worker or as a supervisor of a nurse engaging in a nontherapeutic role with a patient were used. The sample selected for individual and focus group interviews were nurses from a variety of clinical settings and institutions. The sample selected was purposive in that they were registered nurses who had some type experience in a nurse-patient relationship of a nontherapeutic nature. The sample size was not dependent number of participants, but rather on theoretical saturation (Glaser and Strauss, 1967; Krueger, 1998). Data from the twelve interviews were examined for redundancy or theoretical saturation. Because no new categories emerged with interview twelve, theoretical sampling/saturation was achieved.

Data Collection Procedures

Data was collected from twelve registered professional nurses with experience of a nurse moving from a therapeutic nurse-patient relationship to a nontherapeutic relationship. Four individual interviews were conducted from nurses who had personal experience engaging in a nontherapeutic relationship or as a co-worker of a nurse who

had engaged in a nontherapeutic relationship with a patient. The individual interviews were reserved for the personal experiences of the nurse or as a co-worker of a nurse engaging in a nontherapeutic relationship with a patient to ensure privacy and confidentiality of the nurse. The Focus Group consisted of 8 participants and were reserved for supervisors and/or co-workers of nurses who had engaged in a nontherapeutic relationship with a patient. The rationale for not including nurses with personal experiences in the focus group was that the presence of administrative/supervisor nurses would likely inhibit the participation of the nurse with personal experiences, as well as violate confidentiality.

All participants were volunteers recruited through snowballing sampling. The initial contact to potential participants was made by telephone or in person. Qualifying questions included some demographic and detailed characteristics related to the purpose of the research. The qualifying questions determined that the participant: 1) was a registered professional nurse, over the age of twenty-one 2) was able to speak English 3) had personal experience or experience as a co-worker or as a supervisor of the nurse moving from a therapeutic to a nontherapeutic nurse-patient relationship; 3) the memory of the event was sufficiently intact to recall the event, the details of the nurse's behavior leading to the event and the outcome of the event 4) no new incidences were disclosed and 5) was a volunteer (Appendix A).

Once the participant had met the criteria, a general description of the nature of the research was provided. It included the topic of the research, the importance of the

individual's participation and the compensation fee ($25) Prospective participants were given the time, place and format of the individual interview or the focus group session. The starting and ending times of the interview were emphasized. Members were requested to arrive 10 minutes prior to the interview. Once the participant agreed to the interview, a letter was sent to confirm the interview time and place.

Interview Guide

An interview guide (Appendix B) was sent to each participant with the confirmation letter to promote reflective thinking of the experience of the nurse moving from a therapeutic role to a nontherapeutic role with the patient. The ten question interview guide was used for both the individual and focus group interviews. The questions, derived from the research questions, were reflective of what the researcher was seeking to discover.

The interview questions were ordered from the more general to the more specific. The more specific questions were placed near the end of the interview. However, the relative importance of the questions were ordered to place those questions with the greatest importance early in the session. The researcher was interested to discover, what were the processes/events involved at the time the nurse who was engaged in a therapeutic nurse-patient relationship left that relationship to engage in some type of nontherapeutic relationship with the patient. The interview guide was to help gain information about the nurse's beliefs, values, attitudes and perceptions about the therapeutic nurse-patient relationship

Audiotapes of the Interviews

All interviews were audiotaped in their entirety. The focus group interview was audiotape recorded with two machines. One audiotape recorder was placed on the conference table. The other recorder was operated by a doctoral student employed in the computer lab. This machine tracked each participant response by an individual microphone worn by the 8 participants. This technology provided more accuracy for tracking individual participant responses.

Within four hours of the interviews, the researcher listened to each audiotape to note any significant impressions of the interview. This procedure was done to capture any nonverbal behaviors and meaningful pauses that might be pertinent to the phenomena under study. Additionally, any data that was missed due to noise, machine failure or lack of audibility was captured as the notes helped to recall the information.

The audiotapes were then transcribed by a skilled transcriptionist. The researcher listened to each audiotape and simultaneously reviewed each transcript to correct any errors. After the transcriptions were free from errors, data analysis was conducted.

During the interviews, participants used a pseudonym. Pseudonym names provided protection of privacy yet contributed to building some level of rapport. Member participants selected their own pseudonym and as is evidenced from the names selected, some degree of playfulness was manifested among the participants. Participants used their pseudonym during the interview and this name is reflected in the transcripts.

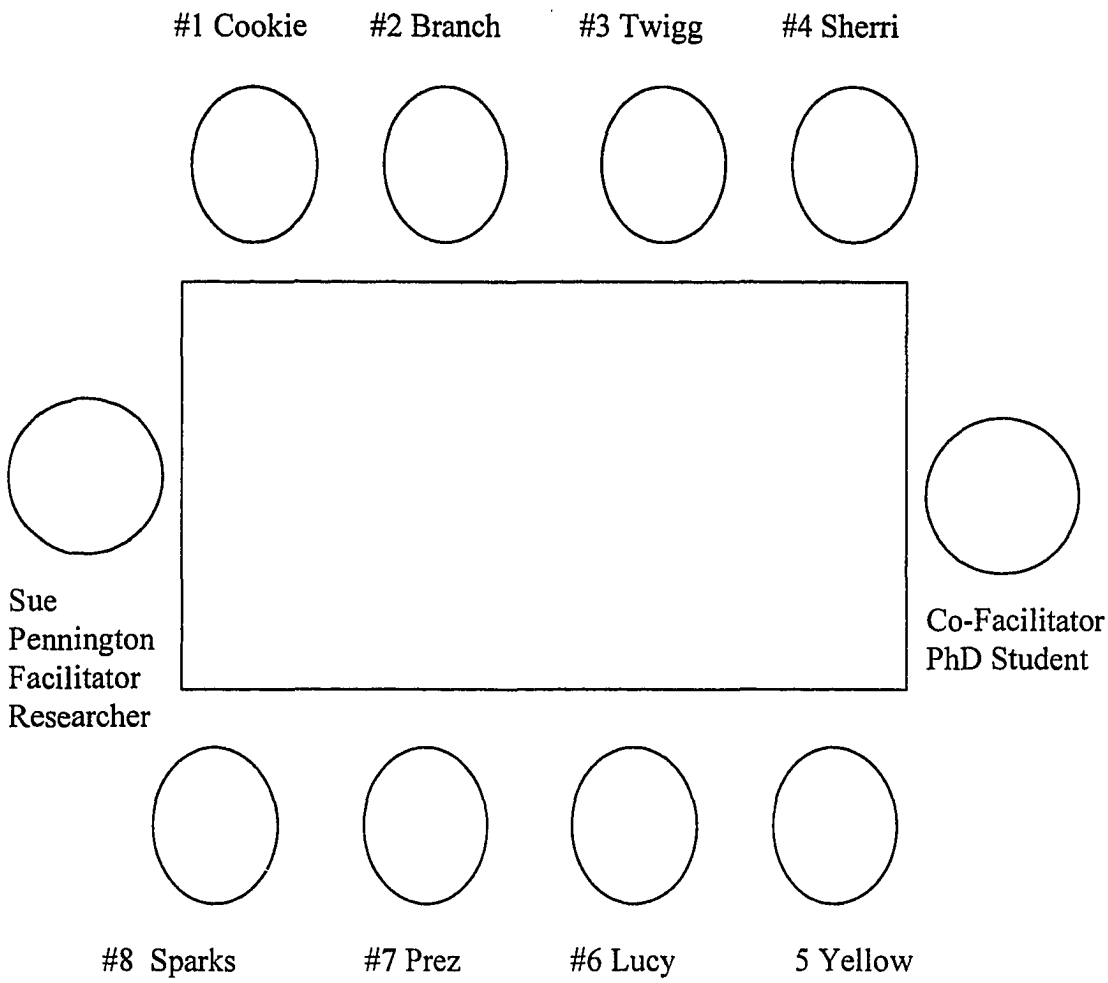
Individual Interview Procedure

The four individual interviews were conducted at a time and place of the parties choosing. A table was in each room and the audiotape recorder was placed on the table. The research investigator sat close to each participant but was not facing the participant and the audiotape interviews were captured in their entirety without any technical malfunctions.

Focus Group Interview Procedure

There were eight participants in the Focus Group; the group was conducted in a large room reserved at the University of Arizona College of Nursing and lasted two hours. A nonthreatening, nonevaluative and comfortable environment was created in-so-far as possible by the moderator/researcher. The physical arrangement of the focus group was structured so all members could see each other (see Figure 3.1). The principle used was that this structure provided maximum eye contact to facilitate group discussion. Additionally, refreshments were provided as a means of enhancing comfort and socialization. Each group member had a table and lapel name tag, using the pseudonym name only.

Figure 3.1 Seating Arrangement of Focus Group



In addition to the participants and the moderator (researcher), two qualified doctoral students were selected to assist and attend the group. One was an assistant to help with group discussion and the other was a recorder. The assistant to help with the discussion focused on the group process to address relevant comments of participants that were not picked up by the moderator/researcher. The assistant was an experienced focus

group facilitator. The recorder had a seating diagram with a list of participants by pseudonym names and made detailed notes during the interview to capture as much nonverbal communication and interaction as possible.

The researcher served as the group moderator and guided the semi-structured 10 question interview process. The focus group was homogeneous in that all individuals had experiences with nurses engaging in nontherapeutic relationship with patients. Heterogeneous qualities of the focus group were that some nurses were administrative, some were clinical advance practice nurses (co-workers) and some were staff nurses from a variety of clinical settings. Education, years of experience, gender and age were also heterogeneous. It was hoped that such purposive reflection of homogeneous and hetergeneneous combined participants would contribute to a greater depth of information, and in fact, participants shared similar experiences, which stimulated reflective thinking in the research area to recall more detailed information.

Human Subjects

Approval from the Committee for the Protection of Human Subjects at the University of Arizona (see Appendix C) was obtained prior to recruitment of participants. Detailed information about the study was provided to all participants and participants signed a consent form that explained the benefits and risks. It included assurances of confidentiality and anonymity. Pseudonym names only were used during the process. A statement was included in the consent form that no new boundary violations should be addressed during the individual interviews or the focus groups. All boundary

movings/violations were to have occurred in the past. This was to insure that no current illegal actions would be admitted by any participant during the Focus Group that might require reporting to the Arizona State Board of Nursing. Consent Forms were kept in a locked cabinet in Room 324 in the College of Nursing.

Data Management Procedures

In this section, data management procedures are addressed. The goal of record keeping was to create a precise and detailed audit trail.

Data was analyzed using substantive and theoretical coding and, was done on each of the interviews. Each interview was coded once the transcription was completed. Core categories were identified along with their properties. As the first interview transcription was reviewed, the second interview was conducted and was followed by coding of the core categories that emerged from the transcript data. Detailed notes and audit trails were maintained with clear references from data sources. For example, theoretical memos were used by the researcher to track theoretical ideas and continuously link and build the ideas while coding (Glaser and Strauss, 1967). The four basic goals in memoing are: 1) to theoretically develop ideas, 2) to record ideas with freedom, 3) to develop a rich fund of memos, and 4) to create a fund of memos (Glaser, 1978).

Four principles were followed when writing and reviewing memos. First, memos were written regularly, from the first day of research to the following days of collecting and coding data. Memos were initiated with the first call to the participant to capture researcher's feelings and impressions. Secondly, memos were referenced as to source

from which they emerged in order to permit return to the memo's origin. Memos were dated, titled, and cross-referenced. Duplicate copies of memos were made with one copy stored in a secure place as recommended by Chenitz and Swanson (1986). Thirdly, memos were reviewed periodically to examine for potential yield of new insights from the data. Lastly, memos were kept separate from the data. Memoing was an ongoing process that began with initial coding of data and continued while the research was being conducted.

Data Analysis

Data analysis is simultaneous with data collection in grounded theory methodology. The constant comparative method was the method for analysis in this study, and was used conjointly with theoretical sampling. The four stages in the constant comparative method (Glaser and Strauss, 1967) are: 1) Comparing incident with applicable categories, 2) Integrating categories and properties, 3) Delimiting the theory, and 4) Writing the theory. These were addressed as they were used throughout the analysis and data collection.

Comparing Incidents with Applicable Categories

The first stage of the constant comparative method involved the researcher coding each incident of the data into as many categories of analysis as was possible. For example, the category of "the nurse-patient relationship" emerged quickly from the first two interviews. The categories emerging next was to discern therapeutic and nontherapeutic variables of the nurse-patient relationship. Coding consisted only of

noting categories on the margins of the interview transcriptions initially but later evolved to an outline of substantive categories (see Table 3.1). The outline was developed so that new incidents could be coded into applicable categories. New incidents were compared to previous incidents and coded into existing categories or new categories were added if the data did not fit into the existing categories. As coding continued, the researcher developed one category that emerged from the data, which was the nurse who had engaged in a nontherapeutic role with the patient was being pulled toward this nontherapeutic role; in other words, the nurse was vulnerable.

As Glaser and Strauss (1967) indicated, the constant comparison of incidents soon generated theoretical properties of the category. The categories were analyzed to think about the full range of each category, the continuum, the dimension and the conditions under which the category is minimized or more pronounced, as well as one category's relationship to other categories. To illustrate, in looking at the nurse being vulnerable, five conditions emerged to contribute to the nurse's vulnerability in engaging in a nontherapeutic relationship with the patient. This process of coding categories, after three to four times, evoked conflicts in the thinking of the researcher, but these musings over the theoretical notions lead to more logical conclusions. The discussions and reflections with the primary faculty advisor also contributed to higher level of conceptualization of categories, which lead to the second stage.

Table 3.1 *Initial Substantive Categories*

Conditions	**Propinquity – Nurse Patient Relationship**		**Outcome**
	Therapeutic	Nontherapeutic	
1. Attraction to Nursing	Nursing attracts caring people, people with morals, people who have a need to be needed.	Many nurses are from dysfunctional families (who violate nurse-patient relationship). Caring people have the propensity to over-step boundaries.	Nurses must have their personal lives in order if they are to be therapeutic.
2. Beliefs/Values of the nurse.	Beliefs/values developed in childhood; learned from parents, teachers, civic, church and nursing leaders. Life experiences shaped values. Philosophy and ethics courses helped develop values. Nurses learned to be responsible for others to examine own behaviors to apply the "Golden Rule" to respect others what is right/wrong.	Some nurses have not developed a sense of boundaries; ethics/ morals not well established. Needy nurses focus on own needs and not patient needs.	There is a special bond between the nurse and patient; the bond is built on self-awareness by nurse, having empathy, being objective, non-judgmental, knowledgeable, and being an advocate for the patient.
3. Education	There needs to be a socialization into the profession of nursing. Teach professionalism in nursing, teach ethics, critical thinking, profession nurse-patient relationships, assertiveness.	Colleges of nursing are admitting a different level of student nurses. Grades/GPA/SAT/ACT scores have priority over selection interviews which look for ethical and moral stability of candidates.	Unless there is a "buy in" to the profession of nursing, through the socialization of nurses, then nurses are just educated for a "JOB". There will be no dedication/commitment to the profession of nursing.

Table 3.1, continued

4. Employing Agency	Hiring screens should look for nurses who are healthy in their mental outlook. Screens should assess if nurse is aware of boundaries, has co-dependent traits, what motivates nurse in caring for patients. Policies should state expectations of nurse-patient relationships. Forums to discuss nurse-patient relationships helpful. Annual Reviews Peer Review Sessions Treatment Plans help spell out patient care, serves to assist all nurses to be consistent and avoid "special relationships" with the patient.	Needy nurses can easily become the "patient", disclose too much personal information and engage in role-reversal. Unclear language in policies defeat purpose of providing guidelines. Nurses can get in over their heads before they know it sometimes-despite good intentions. If the nurse cannot put the intervention in the treatment plan, it is likely nontherapeutic.	Nurses must be healthy and have a balanced life to be therapeutic. Treatment plans are as therapeutic as they are enforced. Secrets are nontherapeutic.
5. Profession of Nursing	Nurses have the State Boards of Nursing to enforce therapeutic nursing practice.	The profession of nursing is hurting itself. There is no clear definition of a nurse. Nursing is a multiple profession 2-3-4-5 year programs (AA, Diploma, BSN, MSN, Ph.D.). Poor salaries do not make nursing attractive. Besides nursing is not appealing. Technology has made more work for nursing.	Salaries affect the nurse-patient relationship. Job satisfaction affects the nurse-patient relationship.

Integrating Categories and Their Properties

The second stage of the constant comparative method involved integrating the categories and their related properties. Incidents in each category are now compared with known properties of the categories identified in the first stage, comparing incidents with categories. The process now involved the researcher looking for explanations or reasons of how the properties of the category are related. The constant comparison and the process of questioning lead to the discovery of the properties that integrated with other categories.

For example, Open Coding in the first stage, comparing incident with categories, resulted in a total of 26 categories with the first interview. The second interview identified a total of 11 categories (see Table 3.2)

Table 3.2

Open Coding Results

Interview	**Categories**
#1	26
#2	11
Focus Groups (8 participants)	20
#3	0
#4	3
Total Participants 12	Total 60

The incidents in each category were examined, but examined in the context of comparing the incident with the properties of the category. The properties of the different categories became integrated through constant comparisons which resulted in the beginning of some

related theoretical meaning. Since the data was collected by theoretical sampling at the same time the analysis was done, (Glaser and Strauss, 1967), the theory began to emerge.

Delimiting the Theory

The third stage, delimiting the theory, occurred when the researcher identified one core category. The process involved a reduction of categories by collapsing the categories into concepts. It is in this stage that the categories became theoretically saturated. The grounded theory emerged from the constant comparative process and the combining categories to develop one core category. All categories are related to the core category. This will be discussed in more detail in Chapter Four.

Glasser and Strauss (1967) state that delimiting occurs at two levels: the theory and the categories. The first level is solidification of the theory. In this level, the theory becomes solidified when the major modifiers become fewer and fewer. *Parsimony* of the variables and formulation of the theory, and the *scope* of applicability of the theory to a wider range of situations are the two identified major requirements of theory by Glaser and Strauss (1967).

The second level for delimiting the theory is the reduction in the list of categories for coding; this occurred with the interview of the eleventh participant. One more interview was conducted, the twelfth, and theoretical saturation was achieved.

Writing the Theory

In stage four, the researcher was faced with writing the theory from the processed data. The memos were reviewed to summarize the major themes. For example, the

major theme of this study was the discovery of the process or events that led a nurse to engage in a nontherapeutic relationship with a patient. This process was discovered by the identification of three stages describing the process of what lead the nurse to engage in a nontherapeutic relationship with the patient. In order to write the theory, the coding recommendations of Glaser (1978) were followed and are discussed as the last section of data analysis.

Coding

The two types of codes in data analysis are substantive and theoretical and both were used in this study (Glaser, 1978). A substantive code conceptualizes "the empirical substance of the area of research" while a theoretical code conceptualizes "how substantive codes may relate to each other as hypotheses to be integrated into the theory."

Substantive and Selective Coding

Substantive codes are the conceptual meanings of the generated categories and their properties. Substantive codes evolved as a result of open coding. Open coding refers to "running the data open" (Glaser, 1978, p. 56) to allow as many relevant categories and their properties as possible to be generated. This helped to determine categories that fit, that work and were relevant to the emerging theory. Each transcribed interview was fractured through the process of open coding whereby each line of the data was examined to identify category and category properties. Open coding helped drive the theoretic sampling decisions before the researcher began to focus on a certain issue. Open-coding was used in stage one of the constant comparative method.

A substantive code was assigned to the data bits to identify the substance of that data. The process of constant comparative analysis was used to compare data with other data and to assign data to categories or clusters according to how the data fit the respective category or cluster. The process was continuous and concepts were emergent in the process (Glaser, 1978). Coding continued until core categories were identified. Once core categories were identified, selective coding for the identified core categories was used for subsequent interviews. Substantive coding was used in stage two of the constant comparative method.

Selective coding referred to the time when the researcher decided to stop the open coding and to just code for the core variables of the theory. The research focus was on the conditions and consequences that related to the core process. Selective coding was when the researcher compared the data sufficiently to delimit the theory to one core category which was breaching the nurse-patient relationship. Only variables related to one core category were coded. This type of coding was used in stages two and three of the constant comparative method.

Theoretical Coding

Theoretical codes emerge from the data; they weave the fractured data story back together to conceptualize how the substantive codes relate to each other as hypothesis to be integrated into theory. Theoretical codes are dependent on substantive codes. "One talks substantively and thinks theoretically of the relationship between codes" (Glaser, 1978, p72). For example, theoretical codes show how the category of being vulnerable

relate to the nurse engaging in a nontherapeutic role. Theoretical codes must earn their way into the theory. Glaser's (1978) summary of 18 possible theoretical codes (p. 74-81) provided guidance for this study to identify the process, *Breaching the Nurse-Patient Therapeutic Relationship*, with the three stages of the process.

Trustworthiness in Qualitative Research

Qualitative (naturalistic) inquiry has the responsibility to provide evidence of research that has been conducted in a thorough, complete and fair manner, just as in quantitative (conventional) research. Trustworthiness in qualitative research is deemed to answer the criteria of rigor in conventional research in terms of external and internal validity and reliability (Guba and Lincoln, 1989; Lincoln and Guba, 1985). Specific trustworthiness criteria addressed in this study were: credibility, transferability, dependability, and confirmability.

Credibility

The criterion of credibility in constructivist inquiry are the equivalent to the criterion of internal validity in conventional inquiry (Lincoln and Guba, 1985). Credibility encompasses activities that make the research more likely to have credible finding and interpretations. Such activities are: prolonged engagement, persistent observation, triangulation, peer debriefing and member checks. Three of these techniques were used for this study.

First, prolonged engagement is the investment of adequate time to achieve research purposes of learning about the phenomena of interest. It includes building

rapport, learning the culture and testing for misinformation. The researcher has been actively involved in the culture and study of nurse-patient relationships for many years. One to two hour sessions were planned for rapport and trust with each participant. Semi-structured interviews and attention to enhancing the process were used. Prolonged engagement should have sufficient time allowed to permit the building of trust. One to two hour sessions were planned for this purpose but pledges of maintaining confidentiality to the participants were used to facilitate the trust process. Lincoln and Guba (1985) emphasize that participants input should be honored during the process and that confidences will not be used against them. This was adhered to during the study. Participants were advised to avoid disclosing any un-reported current nurse-patient relationship violations in an effort to maintain confidentiality and legality of the research process.

Second, triangulation is another mode of improving the probability that findings and interpretations are credible. Multiple sources of data to minimize bias of the researcher were used, such as using two other professionals (doctoral students) and the dissertation chairperson to validate recorded transcriptions and review findings. The two method sources used in this study included individual and focus group interviews.

Third, peer debriefing is an activity whereby the researcher discusses the findings, conclusions and hunches with a relatively disinterested peer. This person presented challenging questions to assist the researcher to 1) process what was discussed in the interviews 2) reflect on how the researcher's values/opinions may have influenced data

findings, and 3) reduce the internal stress associated with the research process. This peer reviewer was an experienced nurse with a Ph.D. in nursing and the primary faculty advisor. The peer debriefing helped to keep the researcher honest through rigorous questioning. Peer debriefing helped to 1) provided an opportunity to test the researcher's working hypotheses, 2) develop and test steps in the emerging theory design 3) assure hypotheses were reasonable and that all interpretations of the data were addressed and lastly 4) to provide an opportunity for catharsis of emotions that clarified judgment (Lincoln and Guba, 1985).

Member checks of participants are described as the most crucial technique to use in establishing credibility (Guba and Lincoln, 1989). Members checks were conducted during and at the conclusion of the individual and focus group interviews. This was done by the moderator and included a summary of participants input to allow for corrections or adjusting misinformation at the time of the interview.

Transferability

The criterion of transferability is parallel to the criterion of external validity (generalizability) in conventional research (Guba and Lincoln, 1989). The technique for establishing transferability is thick description in qualitative research. It is the thick descriptions that enable another researcher interested in the same area of research to reach a conclusion about whether transfer can be contemplated as a possibility (Lincoln and Guba, 1985, p. 316). Thick descriptions were maintained. The thick descriptions maintained present detail, context, emotion and the webs of social relationships that

joined persons to one another (Denzin, 1989, p. 83). Tracking was maintained to illustrate the process of conceptualization into theory, back to the original raw data so this audit process can be done by an outside person.

Dependability

Dependability, like reliability, refers to the stability of data over time. However, in qualitative research, dependability addresses consistency of findings. Guba and Lincoln (1989) recommend a dependability audit be left so that an outside person could follow an audit trail left by the research. The audit trail described procedures used in this study and decisions made in detail.

Confirmability

Confirmability refers to the researcher's ability to produce data, interpretations and outcomes, that are rooted in the data and not the researcher's mind. The data will attest to the neutrality of the researcher through the confirmability audit. The auditability rather than reliability is proposed to be the criterion of rigor relating to consistency in qualitative findings (Guba and Lincoln, 1989) and were done in this study.

Summary of Chapter Three

This chapter described the methodology used in the study. It provided rationale for using the grounded theory method and discussed procedures that directed the research process. The procedures included the maintenance of theoretical sensitivity, a description of the literature review, theoretical sampling, data collection and data analysis. The criteria for evaluating the finished product of grounded theory research was identified as

establishing trustworthiness in qualitative research, which included credibility, transferability, dependability, and confirmability.

CHAPTER FOUR

RESULTS

This chapter presents the results of the data from twelve experienced professional nurses describing the events or processes that lead the nurse to engage in a nontherapeutic relationship with the patient. The first section of Chapter Four provides the participant characteristics. The second section of Chapter Four offers the explanation of the grounded theory and follows the outline summary in Figure 4.1. A summary of Chapter Four concludes this chapter.

Participant Characteristics

Table 4.1 provides a summary of participant characteristics. The typical participant was a middle-aged female with a masters degree in nursing and over twenty-five years of nursing experience. All participants were registered professional nurses who had experienced some deviations in the nurse-patient therapeutic relationship, either from a personal experience or as a co-worker or supervisor of another nurse.

Table 4.1

Participant Characteristics

Gender	
M	1
F	11
Years of Experience	
Mean	30.9
Range	33.5
SD	6
Clinical Area	
Ambulatory Surgery/ICU	2
Medical	1
Long Term Rehab	2
Regulation	1
Pediatrics	1
Mental Health	5
Education Degree	
AD	2
Diploma	2
BSN	3
MSN	5
Experience – N-P Relationship	
Personal	2
Co-Worker	4
Supervisor	6

The next section provides characteristics of each participant as well as a synopsis of their experiences with a nurse moving from a therapeutic relationship to a nontherapeutic relationship with a patient.

Interview #1

Blondie was a diploma degree nurse who worked in ambulatory surgery but had critical care and rehabilitation nursing experience. Blondie submitted a one page written statement of her experience and the following is a brief summation: Blondie's first job as an RN was at a very famous and respected rehabilitation institute in ___. The patients she worked with were hospitalized for 9-18 months, were young quadriplegics or

paraplegics, who were out of state, mostly males, lonely and lacked self-confidence. The employing agency hired new graduates and expected the young nurses to accompany the patients on very nice social outings (concerts, museums, Broadway plays) weekly at no cost to the nurse but on the nurse's own time. Blondie, over a course of time, developed a social relationship with her patient. She was counseled by the employing agency's administration to terminate the relationship. The patient was discharged from the rehabilitation center. The nurse and patient pursued the relationship. They have been happily married for 28 years.

Interview #2

Lucky was an associate degree nurse who worked in an acute care inpatient mental health unit. Lucky's experience was as a co-worker on the evening shift with a female nurse who had married her psychiatric patient. The patient had a history of alcoholism, personality disorder and manslaughter. The nurse (co-worker of Lucky) had kept her marriage to this former patient a secret from the staff. The secret was public information when the patient-husband murdered the nurse as she came home from duty past mid-night. He had turned the gun on himself to commit suicide after murdering his wife/nurse. All staff were devastated with the tragic event. Because of the media exposure, the impact was felt by the employing agency and the nursing profession.

Interview #3

Mary was a master's degree nurse who worked in a psychiatric/mental health setting. The experience recalled by Mary was as a co-worker. She addressed two nurses who deviated from nursing role expectations to make exceptions for a particular physician's patients. The physician encouraged nurses to make his patients "special." Mary's experience was that of a co-worker to two nurses who got involved in some nontherapeutic relationships with patients. The staff were eventually fired from their jobs, including the physician.

Interview #4

CP was a bachelor's degree nurse who worked in nursing administration in an ambulatory health care center with decades of nursing experience. CP's experience was as a co-worker and supervisor. In an oncology setting, a nurse became romantically involved with the dying patient's husband. The relationship ended in marriage after the patient died.

Interview #5

Cookie was a master's prepared nurse who worked in administration for all mental health programs, inpatient and outpatient. Cookie was the supervisor of two nurses who became

sexually involved with patients in the substance abuse programs. Both nurses were terminated from their positions.

Interview #6

Branch was a master's degree prepared nurse who was employed in the field of nursing regulation. The experiences recalled by Branch included several investigations by the State Board of Nursing, in more than one state.

Interview #7

Twigg was a master's degree nurse who worked as a clinical nurse specialist in mental health outpatient clinic. The experiences of Twig was as the clinical nurse specialist who worked with nursing staff at the time of the tragic event, the murder of the nurse who had married a former psychiatric patient. Twigg served to provide emotional support to staff at the time of the tragedy.

Interview #8

Sherri was a diploma degree nurse who worked as a part-time staff nurse in an acute care psychiatric and substance abuse unit. Sherri was also a co-worker of the nurse who was murdered by her patient-husband. Sheri recalled that the nurse who was murdered had accepted numerous gifts from her patient, (later husband). The nurse was a single parent with financial limitations. The patient-husband met some of the nurse's needs seemingly. He helped her financially but was also known to be charming. The marriage was not discussed by co-workers until the nurse was murdered.

Interview #9

Yellow was a bachelor's degree prepared nurse and worked as a clinical nurse manager in critical care. Yellow shared experiences from both ends of the spectrum of the nurse-patient relationship. One experience was the nurse being overly-involved while the other experience was the nurse being under-involved. The over-involved experience Yellow described was as a supervisor and it involved the nurse, on drugs, taking money from his patients. The other experience of the nurse being under-involved was Yellow's personal experience as a patient, hospitalized with a pulmonary embolism and the grossly inadequate care she received from agency nurses. The nurses were not present for her, despite her being in severe pain, being a critical care nurse and knowing the gravity of her condition. The nurses seemed incompetent and non-caring to Yellow.

Interview #10

Lucy was an associate degree nurse who worked in rehabilitation nursing as a supervisor. The experience of Lucy was as a supervisor in a long-term care setting and in making her nursing rounds one day, learned from a motherly type patient that the evening nurse had revealed much personal information to the patient. The patient had observed that the nurse was upset and inquired as to what was wrong. The nurse disclosed an abusive marital relationship and in fact had been abused before coming on duty. The patient became the counselor listening to the distraught nurse; there was "role-reversal" between the nurse and patient.

Interview #11

Prez was a bachelor's degree prepared nurse, employed in the pediatric field of nursing as a supervisor. The experiences of Prez were representative of the pediatric nurse perspective, both as a supervisor and as a personal childhood experience as a patient. As a supervisor, Prez experienced nurses engaging in nontherapeutic roles with the pediatric patient's parents by giving faulty and unethical advice to the parents; the nurses were over-stepping the professional nurse's role. As a personal experience, while in childhood, Prez experienced pediatric nurses caring for her to be disrespectful of her preferences by discounting her. This experience was powerful enough that Prez resolved to become a pediatric nurse and treat children with respect.

Interview #12

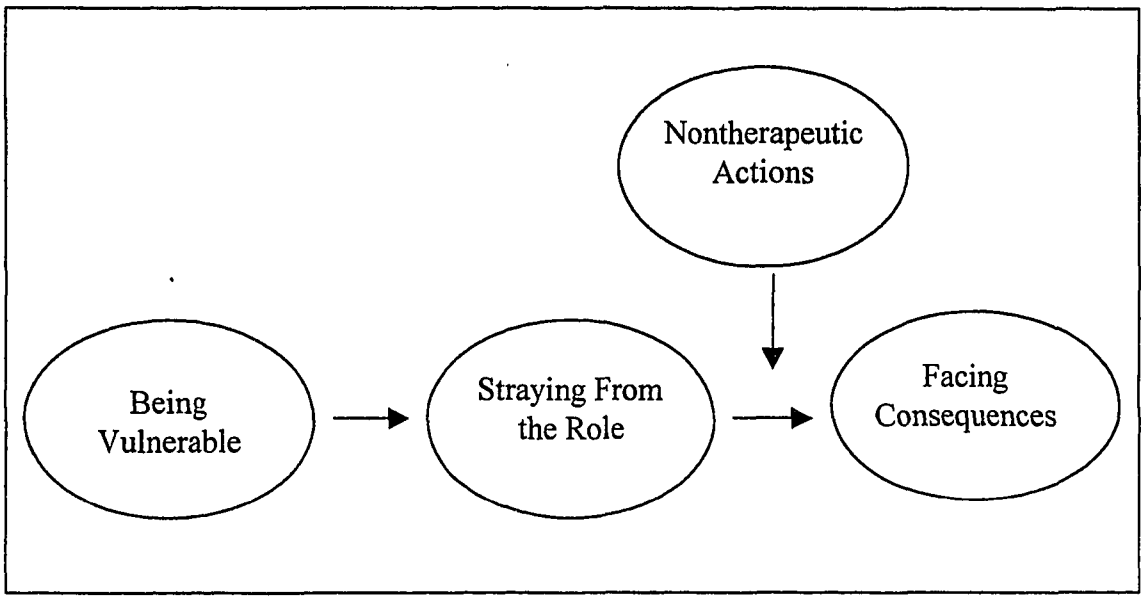
Sparks was a master's degree, clinical nurse specialist in cardiology. Sparks, via snowballing sampling and an interest in the research subject, came to the Focus Group and shared her personal experience of the nursing care her father had received recently. Nurses were not available to her father – they were cold, distant, aloof and unavailable. This personal experience of Sparks was another representation of the under-involvement on the continuum of the nurse-patient relationship and was very nontherapeutic. Sparks viewed the experience as damaging to the nursing profession.

Explanation of the Grounded Theory

The core category identified in the grounded theory is the process of *Breaching the Nurse-Patient Therapeutic Relationship.* Figure 4.1 depicts the *Breaching of the Nurse-Patient Therapeutic Relationship* process. There are three general stages in the process as identified by the grounded theory: *Being Vulnerable, Straying from the Role,*

and Facing the Consequences.

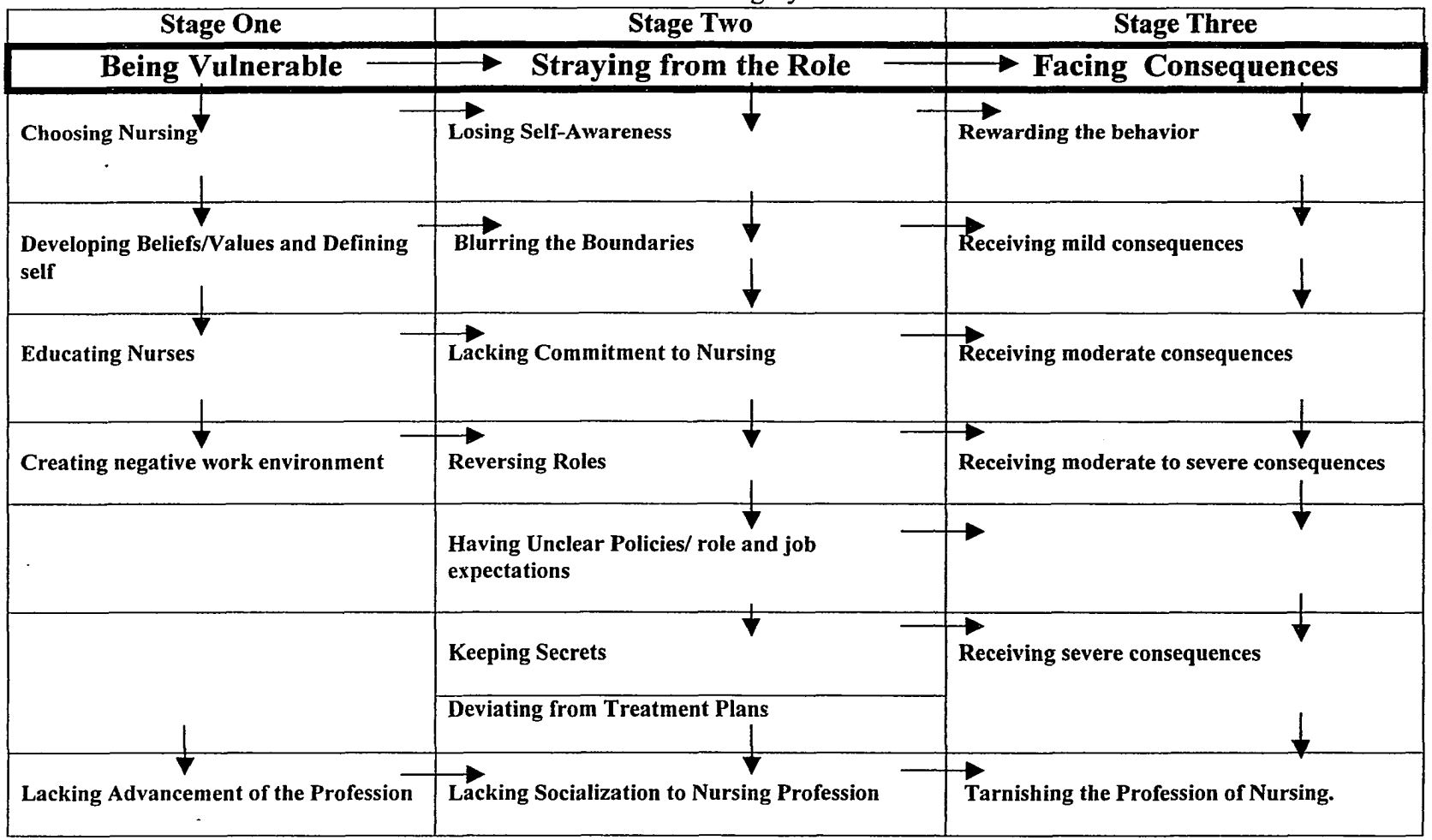
Figure 4.1 The Process of Breaching the Nurse-Patient Therapeutic Relationship



The model is presented in relation to these stages in the process of the nurse breaching the nurse-patient therapeutic relationship. In Stage One, *Being Vulnerable*, there are some identified characteristics that set the stage for the nurse to proceed to Stage Two, *Straying from the Role*. In Stage Two, the nurse proceeds to breach the therapeutic nurse-patient relationship but the process is concluded in Stage Three, *Facing the Consequences*. This is where the behavioral actions of Stage Two are addressed and it finalizes the three-stage process. Each stage has a process that includes specific characteristics. Stage One, *Being Vulnerable*, has five identified conditions contributing to Being Vulnerable. Each condition has some process characteristics specified as sub-headings. Each corresponding condition under Stage One is put in parenthesis in Stages Two and Three,

to illustrate the progression of conditions in the three stage process. In the third stage, *Facing the Consequences*, the process is also depicted in severity of consequence. Each stage will be discussed in the following sections.

Figure 4.2 Grounded Theory: Breaching the Nurse-Patient Therapeutic Relationship
Theoretical Category Names

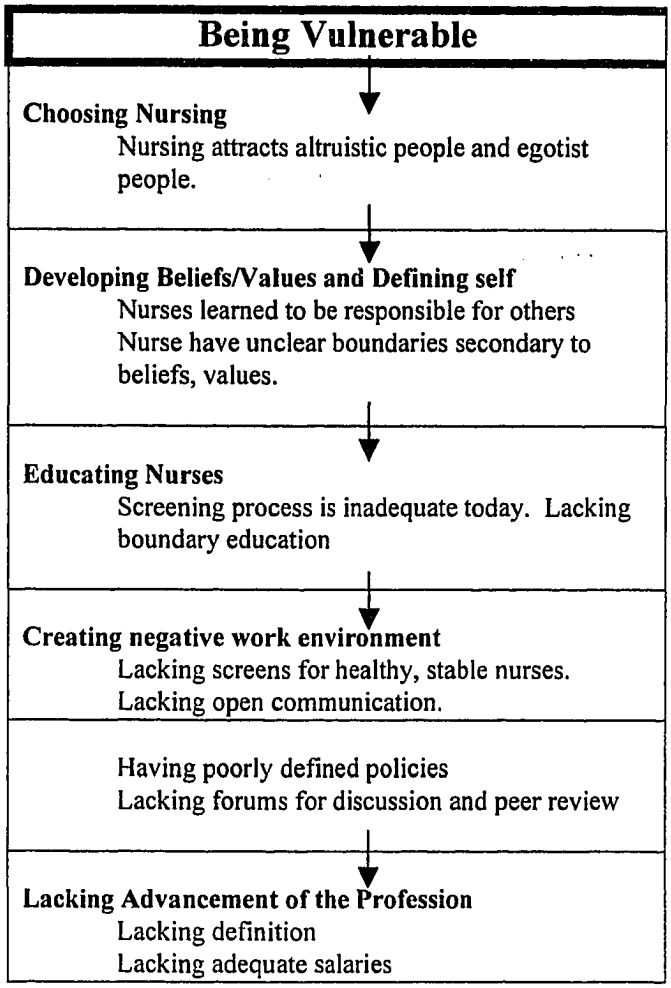


Stage One: *Being Vulnerable*

The condition or requirements for the process of the nurse *Breaching the Nurse-Patient Therapeutic Relationship* begins with the nurse being vulnerable. *Being vulnerable* in this context is defined as when the nurse is affected by a specific influence or temptation and as a result becomes vulnerable to engage in a nontherapeutic relationship with the patient.

Figure 4.3 presents *Being Vulnerable* in *Breaching the Nurse-Patient Therapeutic Relationship.* There are five conditions in Stage One that begin the process for the nurse to become susceptible to breaching the relationship. These conditions are Choosing Nursing, Developing Beliefs/Values and Defining Self, Educating Nurses, Creating a Negative Work Environment and Lacking Advancement of the Profession. Each condition will be presented as part of the three stage process.

Figure 4.3 Stage One



Choosing Nursing

Choosing nursing is defined as describing the two types of people who choose nursing as a profession. These two types are altruistic and egotist. Altruistic people are those people who are concerned for the welfare of others; these are caring people who have morals or who need to be needed as illustrated by:

"...People who go into nursing have needs that they like met through their jobs. It's like an engineer when he goes to work and he builds that bridge. Well, it makes a nurse feel good to see a patient do good, get well, or you know, die peacefully or you know,

whatever the goal is of that patient." Blondie (287-294).

"...I knew at 17 what I needed was to be needed and my perception of how I could meet that need was to be a nurse." CP (344-347).

Nursing attracts people who want to make a difference.

"Yes, I'm a real positive believer in people. So yes, I don't think that anybody chooses to go into nursing who doesn't have some of those very basic moral values." C.K. (844-847).

"One of my first experiences was as a patient and being in a rural area...a very young pediatric patient...I had a nurse who did not respect me as an individual...I remember very vividly telling my dad that I wanted to go into the medical field...I wanted somebody to know how to care for a child and know the feelings they are going through and to treat them with respect..." Prez (1286-1305).

It is clear that nursing is a major attraction to people who need to be needed and want to make a difference in the lives of other people.

In contrast, the second type of people who choose nursing are the egotist; people who look to nursing to meet their own unfulfilled self-needs. Nursing attracts individuals who are from dysfunctional home environments who are "needy nurses". In other words, they have many unmet needs that they try to get met through their chosen profession. State Board of Nursing investigations and experiences of nurses reveal that many of the nurses who have engaged in nontherapeutic relationships with patients are from very dysfunctional families.

"...so I (Investigator) love going out and seeing that nurses are not all in trouble. Our nurses have horrendous dysfunctional families. At least the ones that I come in contact with. Situations that I absolutely cannot ever believe..." Branch (1024-1029).

"...It seems to me (as the nursing administrative supervisor) that both of these people (two registered nurses) had no support at home..." Cookie (320-321).

The nurses who engaged in nontherapeutic relationships, as recalled by the participants in this study, identified the nurse as being vulnerable because their home environment offered no support or they were abused either physically or psychologically.

"I worked in a rehabilitation setting and saw patients stay a longer time and the nurses often get to know them very well...on this particular night the nurse came in and had a discussion with the patient that led the patient to realize that something was not quite well with her and she was not her usual self...the following morning when I was making rounds, talking with all of the patients...to my disbelief almost she (the patient) started to unfold this story of events from the night before...the nurse was apparently involved in a violent relationship and had been abused the day before she came to work and feeling this bond already developing with this elderly, motherly type of patient, she (nurse) started to cry a little as she was working... " Lucy (558-588).

"Well, I think that she (nurse) was putting her personal needs first...financial. She was taking care of 2 or 3 grandchildren... " Lucky (209-213).

"I think that ...when we got into, discussions about what it was like to be working with these patients...these nurses saw less of a need to hold to particular standards....didn't see problems with them (patients) having special privileges beyond what other patients had...or why they (nurses) shouldn't spend hours with one patient while the other patients on their team perhaps didn't have any time." Mary (558-569).

"For those individuals (nurses) it was like they were having their own needs met – it meant more to them than meeting the needs of all the clients in the agency. It didn't seem like it was wrong to them to engage in this type of behavior." Mary (589-594).

In summary, people choosing nursing are contrasting types – the altruistic and egotist. Both types are vulnerable to breaching the therapeutic relationship.

Developing Beliefs/Values and Defining Self

The types of beliefs/values and definitions of self developed by the nurse are an essential part of whether or not the nurse will become vulnerable. Many nurses developed their beliefs/values in childhood; they learned "right from wrong" from parents, teachers, civic, church and nursing leaders. Many nurses felt their life

experiences helped shape their values. One nurse felt philosophy and ethics courses helped her develop her values.

"...my first degree was in philosophy and we had ethics galore and I loved it. I loved it! That is something I came into nursing with (1179-1185)...I consider myself fortunate having this liberal arts background because it was also at a Catholic University that I went to so we had theology...It gave me a sense of who I am and that reflective ability to look at yourself." Sparks (1163-1165).

Others applied the "Golden Rule" to their nursing practice.

"I really didn't have anything going right from high school into nursing school. No sense of grounding. I knew according to the Ten Commandments what was right and what was wrong..." Twigg (1212-1216).

"...Knowing what is right and wrong I would definitely say came from my parents..." Prez (1308-1309).

Some nurses have not developed a sense of self and boundaries, their ethics/morals, beliefs/values are not well defined and this lack of direction makes the nurse vulnerable to engaging in nontherapeutic relationships with patients. Nurses who lack this self-awareness also seem to have weak value systems that contribute to their being vulnerable.

"The two situations that I will speak of actually involved male nurses caring for female patients. They offered to give back rubs or massages to patients that were in pain....one patient had been in bed for a long time and her back was bothering her...the nurse offered a back rub...which is very appropriate. We all do those things. It got out of hand and led to sexual misconduct. The other patient was in the emergency room....but I think in both cases, the individual nurses had some kind of attraction to these patients and didn't either identify that the fact that they did and then select not to take care of that patient. I think that is a responsibility that nurses have...to recognize some kind of attraction to a patient...and not care for that patient." Branch (328-355).

" The two situations that I was involved with was a very interesting metamorphosis...we had discussions...and it seems to me that in one instance, they were very specifically asking.... 'Tell me exactly what it means to be in a nontherapeutic relationship with a

patient.' They were further asking for ...the definition of a patient. If a person has been discharged for 30 days and I meet them again out of the hospital, is he....an acquaintance and no longer a patient? The one person...asking for those definitions...found herself involved with a second patient...the other individual had watched the first person go through this whole thing. Had sat through all the staff meetings...and still found herself in the same relationship...they were not able to break the link between their personal life and their professional life. They knew that they were crossing over but for some reason, they weren't able to stop themselves." Cookie (296-327).

Self-awareness by the nurse was a critical factor and was strongly addressed by CP throughout her interview.

"...I would see my own self-awareness coming from '84 when I divorced my first husband, or he divorced me, and at that point in my life, recognizing that I was at a very young age, who and what I was about and what was important to me. But by 1984, I didn't even know what I wanted. I didn't know who I was anymore. So I did lots of counseling from that and got back in touch with what, who I was and learned what I saw my true value then in my life related to nursing and helping people...." (368-380).

"...Unless you have that (self-awareness) you can't really understand what the patient is thinking, feeling and where they are coming from fully..." (393-398) "...there is something about time and relationships that are the boundaries." (568-569).

"Well, I think it's your self-awareness." (208).

"...you've got to be able to articulate that self-awareness of what you're thinking about and you're doing and why you've made those decisions to have that relationship or to take that action..." (760-764) "...I think it (boundary violations) happens before they (nurses) really recognize it and then they don't know where to go or it's too late to fix it." (907) "It's lack of awareness." (870-873).

Each of the twelve participants emphasized that a key element in maintaining nurse-patient relationship boundaries was through defining one's self and being aware of one's beliefs and values.

Another aspect of the beliefs/values of the nurse is the sense of responsibility. Nurses have learned and believe they are responsible for others, often verging on being

co-dependent or fostering dependency of the patient on the nurse. Nurses often assume responsibility for others while ignoring their own needs.

"We'll, I'm the oldest of 4 children. We were poor...I had a lot of responsibility as I was a child. From the time that I was a little child I had a lot of responsibility...my dad was the chairman of the board and the deacons in the church...and there was a lot of pressure on me to be an example with the expectation of our family....so at a young age, I learned to examine my behavior....we had to think if this (behavior) was pleasing to God., then, was it pleasing to my mom and dad and what would be the outcome..." Blondie (440-460).

Nurses feel responsible for others to the degree that often the nurse will ignore his/her own self-care needs.

"...we are notoriously bad at taking care of ourselves...we have to have a life outside our profession..." Twigg (392-394).

Sherri added, *"...as the saying goes 'Heal the healer.' We always give and give and we need time to take care of ourselves...like sharing with co-workers. The case I recalled is the nurse having financial difficulties. She was a single parent. This patient, who she is married to, provided those needs. That is where the fine line is...it's fulfilling her needs..." (403-412).*

However, Twigg posed an interesting question: does the nurse need to be so responsible to the patient?

"How much help does the client need to become as well as he or she can become. I think sometimes we feel that we are more responsible for the caring of a patient than is really helpful to the patient." (93-99).

Yellow agreed that caring people sometimes over-respond.

"I agree with Prez and Twigg in that we sometimes, because we are the caring kind of professionals, jump in too soon and not ask (the patient) what are your needs? What are you expectations that I am going to be able to help you with? What are you planning to be able to do on your own..." (123-127).

In summary, nurses who had not developed a sense of self, with ethical and moral

values, as well as self-awareness of boundaries, were vulnerable to breaching the therapeutic nurse-patient relationship.

Educating Nurses

Educating nurses is concerned with screening candidates who enter nursing programs and presenting course content related to therapeutic nurse-patient relationships. These factors contribute to the nurse being vulnerable. Some participants believed that the nursing shortage has contributed to a change in admission standards in nursing education and that unsuitable candidates enter nursing programs today. In the past, the focus of screening nursing candidates emphasized the morals/ethics of the nurse through extensive interviews. Candidates were screened to determine the reason for entering nursing.

"...I think we used to really screen who became a nurse. I remember going to nursing school and having the nursing instructors be absolutely out of their mind, crazed, because the top A student in our class came in leather hot pants and a crop top and there wasn't a dadcome thing they could do about it because she was the best student in the class. But, that was not the moral picture that they had of what a nurse should be doing. So, has nursing as a profession transitioned from the kind of interviews that some people in this room had....to get accepted into nursing to the interviews that I and Sparks never had, but if you had good grades...that is what you had to get into ....What is the acceptance now...so, we don't have the screening that we had when many of us in this room were applying to nursing school It was more of a difficult thing to get into..." Cookie (1760 - 1790).

"...I'm finding out that nurses go into nursing now for different reasons. A lot of them who get their associate degrees go in because they are single moms and they need to make a good income. They're not going into it for the same kind of reasons that I think that maybe the 10 or 11 of us got into nursing for....They (today's nurses) don't have the "buy in" to the profession of nursing. They don't see it as a profession. They see it as a JOB. So, I think that is why some are not therapeutic...". Yellow (535-551).
"...before I was even admitted into the diploma program, I had a battery of psychological tests. There was an interview with my mother. There was an interview

with myself. There was an interviews with my brother who happened to be 9 or 10 years old at the time. There was a family interview before I was even accepted... " Branch (1012- 1019).

"...my testing was in the form of a rigorous interview in a diploma school... 'Why do you want to be a nurse?" Yellow (1056).

In contrast, this intensive interview screening process was not done with some of the newer graduates. Sparks, (a younger nurse), *"I had no testing (entrance) like that." (1046)*

One stated, *"Took the SAT's and the ACTs (entrance examinations). I don't recall any interviews by the nursing program. I think you just applied." (270).*

Eight participants in the focus group addressed the lack of screening as an issue and reflected on whether they had the interviews to determine their fitness for nursing. To summarize, three of the eight participants in the Focus Group took entrance examinations to enter nursing. Five of the eight participants had no examinations.

In addition to screening for suitability for nursing, participants stated that program content on nurse-patient relationships has not been integrated into the educational process as effectively as some nurses would like. It is well integrated into some programs and helped shape the nurse's belief/value systems toward keeping the nurse-patient relationship a therapeutic one. In others, it is not addressed sufficiently.

"Well, I think a lot of beliefs and values you develop in childhood...these are carried over into the nursing profession. The first time I became aware of boundary issues with patients, of course, was in nursing school where they taught the boundaries and the reasons and the what fors... " Lucky (225-233).

"Well they (nursing faculty) of course taught the boundary issues and gave you more insight into why there are boundary issues and why there are boundaries issues in nursing... " Lucky (242-247).
"I would say it was just a lecture at one point in nursing school... " Lucky (249-520).

Blondie recalled a different learning experience from nursing school that was in contrast from her family values. The boundaries of relationships was expanded to include fun but lacked fairness in Blondie's nursing program Blondie found the nursing triad in the school's administration confronting her about her socializing with her patient, yet at the same time, the triad was engaged in a romantic/dysfunctional relationship.

"well, yeah, because I was raised in a strict environment and then I went to nursing school and then I found out that everybody else wasn't raised like that (laughter). That there was fun out there. I had a good time...I never got into a lot of trouble...but I always stood up for myself...I learned to stand up for myself. So, when I did hit a couple of rough spots in nursing school, and thought that what was being done wasn't fair, I was able to stand up for it..."(480-496).

Most nurses stated that the need is still present today to include nurse-patient therapeutic relationships as part of educating nurses and that they believe more content should be focused on prevention of violating the therapeutic relationship.

"...I think it's (professional boundaries) an areas that needs to be addressed...it's an excellent topic to deal with in their psychiatric nursing class..."
(281-284) "...those (psychiatric) instructors should be at a good point of being able to discuss it (boundaries) with them (students) and had some discussions with students based on that..." Mary (275-276).

In summary, the third condition in *Being Vulnerable*, is Educating Nurses. If unsuitable candidates enter nursing and the nurse lacks sufficient content on the nurse-patient therapeutic relationships, then the nurse may become vulnerable to engage in *nontherap*eutic relationships with the patient.

Creating Negative Work Environment

The fourth condition in *Being Vulnerable* focused on the work environment of employed nurses. Creating a negative work environment by the employing agency was

identified as a significant factor in the process of the nurse *Being Vulnerable*. Employing agencies have the responsibility to provide a safe environment for nurses to practice nursing. Many factors were addressed about how to create a work environment. One factor was having an open communication process where nurses feel safe and comfortable to talk about nurse-patient issues. Another was that nurses need to feel safe to call in sick if they are emotionally distraught or incapable of performing job duties.

"We have to allow our staff to be comfortable enough...to open the line of communication to management. ...This nurse was probably so timid about coverage, shortage of staff, never thought well, maybe I need to talk with the supervisory and be up front with her without feeling that I'll be judged if I don't want to come to work..." Sherri (858-868).

"I will just share something that occurred in another state with another board of nursing...we had a nurse who appeared before the board in this other state because a complaint had been filed that she had abused an elderly patient in a nursing home and by doing that she had slapped the patient in the face and had knocked the patient's false teeth out. As we investigated it, and what came out, both in the investigation and before the board at a hearing, was that the nurse was responsible for taking care of her aunt and her mother. One of them had had a CVA and had just come home from the hospital and the other one had cancer. I don't remember what kind of cancer. But she was caring for them in her home. She was also very, very close to her grandmother who also lived with her but the grandmother had been put in the hospital with pneumonia. She called in sick and said " I just can't work I've got too much going on. My grandmother is in the hospital" and she was told by her employer you either come to work or you'll lose your job. So she went to work and was passing medicines and as happens in long-term care facilities, the patient spit the medication out in her face and that was the straw that broke her back. And I am certain that this nurse was not an abuser but it was more than she could handle. She didn't recognize that she couldn't have gone to work even if she lost her job in this situation. Then back to what Cookie was saying, sometimes we put nurses in those situations." Branch (869-904).

There is a need to permit nurses to have personal counseling when the nurse is in a crisis and unfit to work. Currently, most work environments negatively sanctioned nurses who may need such counseling.

"...On the one hand we tell them they must set professional, personal boundaries but that doesn't mean on the one hand that they come to the supervisor for counseling. Nor does it mean that we don't care that they have personal problems and that we don't recognize them as personal. We have to let, I believe that we have to let our nurses know that when they have personal problems that there is help available. There are counseling. There is counseling available. And to be understanding regardless of how critical our situation is because sometimes people are not fit to come to work. It might be that you need them desperately but if they person is not fit then they ought not to be there." Twigg (906-922).

Nurses need to feel free to make personal judgements about their ability to care for others. Nurses need understanding managers who allow nurses to report to duty in a healthy state but to call off for sick leave when the nurse determines that he/she cannot perform safely and therapeutically.

"...I think we need to bring empathy and how we act to each other as co-workers. How we treat other people but I think we need the same relationships as nurse managers with out staff as we do with out patients and it's going back to even what Lucy said and even back to the 2 nurses that I was dealing with when they first came to me and we had these conversations and we talked about it. This is not safe. This is not healthy. You need to deal with it. Then you have to be fair and you know after parenting 3 children you always look...I look at many things as parenting. Here are the rules. You make your choices. You are the grown up. If you cross the line you are responsible for those actions. I think many times in nursing and in the kind of things that we are talking about because it's hard to write it down in a policy, because it's hard to be real specific, because maybe it's uncomfortable for patients, because maybe there is a difference the way it is in a med/surg unit than what it is in a psych unit but we need to have some kind of policy in writing and we need to be able to talk to the nurses about that and then we need to hold them accountable for their behavior. They need to hold us accountable that if they call in and say I really can't come in today because just everything is a mess and I'll call you tomorrow and I'll be in tomorrow. We need to give them that leeway. We also need to say that this is your job and you can do that once or twice but after that I don't have the leeway. We got to run a business and we have to take care of other sick patients here so I think we need empathy in our co-workers and I think that is a good question Sue. I think that is how we need to live our life with our co-workers as managers, as nurses and in our whole life." Cookie (1529-1569).

The creation of a positive work environment was discussed at length. The

employing agency has a role creating a positive rather than a negative work environment. One way to address that is knowing that satisfied nurses perform more effectively and key aspects of satisfaction are retention and salaries.

"If you're talking about what the nurse needs to have in order to be therapeutic to her patients, then obviously if I feel like I can pay my bills and my kids have their lunch money, I'm going to feel better about myself and therefore I'm going to feel better about my job." Twigg (1709-1715).

"I think administration is going to have to get more creative about the retention of our caregivers at the bedside. It's not that we have a nursing shortage it's that we have an unwillingness of our nurses to get back at the bedside or even go there in the first place to care for people. We have to make it more appealing for them to do that. Whatever that is going to take." Yellow (1625-1633).

As part of the retention issue, participants believe that the screening process for hiring qualified nurses is inadequate. Similar to the screening of suitable candidates prior to admission to nursing school, nurse managers should interview job applicants to determine if the nurse has healthy boundaries/healthy beliefs about nurse-patient relationships. It is a responsibility of the work environment to hire competent, healthy, emotionally stable nurses, thus creating a more positive work environment.

"...As a supervisor of a pediatric program when I did an interview, I sat down with each individual nurse and presented certain situations that dealt with what would be therapeutic to the family. What would not. How would you handle certain situations. I could tell from my own background as to would they cross over the line...so I would sit them down first off and if the individual sounded like she really was a good nurse but just maybe needed some guidelines on how we handle certain situations..." Prez (278-294).

Further, the policies of the work environment may contribute to a nurse engaging in *nontherap*eutic nurse-patient relationships when the language and expectations of the policy on nurse-patient relationships are vague, contradictory or ambiguous.

"...I believe that the nurse had probably been in this relationship with the situation for some time and had been able to come to work and do her job...In this particular time, I think she was starting to realize that is was getting really bad and that she needed help...." Lucy (923-931).

"...but we need to have some kind of policy in writing and we need to be able to talk to the nurses about that (crossing the line in nurse-patient relationships) and then we need to hold them accountable for their behavior..." Cookie (1552-1556).

Work environments should have procedures to refer nurses who need help.

"...you can also, ...refer them (nurses) to the necessary resource if they need help." Sherri (1745-1747).

The work environment should ensure that their preceptor and orientation programs include guidelines for nurse-patient relationships.

"I think another part...that I see on a fairly regular basis is when we have a new nurse, whether it be a new grad or an experienced nurse coming into a new setting, often times I see that the nurse who is assigned to be the preceptor is so busy that they don't have time to set the ground work and really do a good job. So I find, unfortunately, that we are not doing a good job of orienting people to the facility, that we did a few years back." Lucy (1973-1803).

"...code of conduct and ethics and compliance for the hospital" (as part of orientation at the facility). Lucy (1808-1809).

Preceptor and orientation programs in the work environment can serve to assist nurses in effectively transitioning into the new agency by creating a congenial and positive work environment that facilitates quality care. However, if such preceptor and orientation programs are compromised, then a negative work environment may be created as nurses will not be adequately prepared.

"It seems to me like employers are responsible for the patient care that is given. I mean, that is obvious. When a patient is admitted to an institution or facility of any kind, they are responsible for the care that is provided. Therefore it would seem to me that they should be held responsible if their employers are not providing that care which equates

to therapeutic relationship as well as the technical kinds of skills." Branch (2072-2081).

Nurses, in a positive work environment, can be proactive in preventing co-workers from breaching the nurse-patient therapeutic relationship if there are forums used to address relationship issues.

"...wouldn't you say that if you are a nurse...and nurses may not have the gut feeling that you, as a co-worker have, you have an obligation, not just to yourself or to that nurse, but to the nursing milieu, as well as to the patient more so, to personally meet with that nurse..." Sherri (269-276).

The lack of such forums creates a negative work environment by facilitating nurses to act in nontherapeutic ways. The propinquity of a nurse in borderline situations of a nurse-patient relationship is likely to result in the nurse breaching the relationship. This is where peer review sessions may be helpful. A nurse gains more self-awareness by being able to articulate his/her awareness, experiences, feelings with co-workers and peers. Peer reviews offer the nurse an opportunity to discuss feelings/attractions/resentments toward a particular patient. It is a good time to discuss what the nurse's motivations are in terms of caring for patients, particularly if exceptions are being made for one patient and not other patients.

To summarize, in the fourth condition of *Being Vulnerable*, Creating a Negative Work Environment, a number of causes of creating a negative work environment were addressed. The participants identified the lack of adequate screens for hiring healthy nurses, the lack of communication channels, the lack of policies that define the nurse-patient therapeutic roles, the lack of forums, such as peer reviews, for discussing nurse-patient relationship issues as problems in creating a negative work environment.

Lacking Advancement of the Profession

Lacking advancement of the profession is defined as the profession of nursing not having a clear definition of what is a professional nurse. The profession of nursing has not clearly defined what constitutes a professional nurse and this lack of clarity contributes to the nurse being more vulnerable to engage in nonprofessional conduct. A nurse is more vulnerable to breaching the therapeutic nurse-patient relationship if the nurse does not know and meet the standards of a professional nurse.

"Well one of the things for me coming into nursing later was all these different levels. You know you can become an LPN, 2 year, 3 year, 4 year, or 10 years. That confusion to the clients and the profession itself is perhaps not bad. You can look at and say that if offers a lot of variety. But to call it a profession, it's probably multiple professions lumped under the name of nursing. But I think part of professionalism is having some goal that you can work for and get paid more for and take on more responsibility and you aren't going to hit this ceiling. Now with women being able to go into whatever they want to they are going to go into computer science and get $100,000 a year right out of college where nursing you get $40,000 on the floor you know...go figure. You know, Nursing is going to hurt itself. Money is always an issue. There is not a lot around but how do we make the profession more attractive to a higher level of pay." Sparks (1588-1610).

Additionally, many health care providers are categorized under nursing and these lesser educated staff also violate boundaries of the "nurse"-patient relationship while the profession of nursing accepts the damages. It is unclear to the public just what is a nurse.

"I guess the more I think about the nurse/patient relationship, ...I think it's an issue that needs to not be ignored in nursing....nursing education....whether you want to call them nurse extenders or whatever....that one of our dangers...is that we are using people that have not had the kinds of educational process..." Mary (727-742).

"...I not talking about agency nurses. I'm talking about whether it be your psychiatric technician, a nurse tech, other people....they are in danger in crossing the therapeutic boundaries...."(745-756).

In discussing Lacking Advancement of the Profession, participants had mixed feelings about how poor or low nursing salaries contributed to a nurse breaching the nurse-patient relationship. Participants acknowledged that money speaks to the salience of a profession.

"In addition to that you say computers...my son is making much more (money) than. More than that. It hurts but it's good to hear that your son is doing good. But on the other hand, other than money, which we do have to be realistic, money is needed in every career and in life in general." Sherri (1612-1617).

"In relation to our financial reward. Being a mother of young children I often talk with my children that often times your profession isn't only about money. I've told them many times that if I had to stop with my nursing profession right now I would be very satisfied. I've done a lot of things. A lot of different things and I'm very proud of what I've done. I think that that as a society we need to teach our children and nurses and other professionals. Are you happy? Are you proud of what you are doing with whatever job that you are involved with? It would be great if money wasn't everything but you know money does put food on the table and buy shoes for kids that are growing and growing and growing. It certainly would help but I think that as nurses you also need to focus in on satisfaction and other things that are involved with the nurse/patient relationship." Prez (1658-1678).

Money and salary influence where people work, who is attracted to nursing, and may influence a person's security needs being met.

"...but at the same time if you look at all of us here we didn't look at the money but the new nurses coming now they are moving along and they are going where they can make the money. That is the sad part but money talks." Sherri (1680-1685).

The profession of nursing has let the profession down by not addressing salaries.

"It's sad to know that you've been in practice for more than 20 years and that salary really hasn't increased but then there are other things that have benefited too." Prez (1686-1689)

In conclusion, the last condition, Lacking Advancement of the Profession is defined as the profession not defining what constitutes a professional nurse. Some

nonprofessional staff, called nurses, contribute to the problem of engaging in a nontherapeutic role with a patient, but the blame is on the profession. The lack of adequate nursing salaries was addressed as contributing to not advancing the profession.

Summary

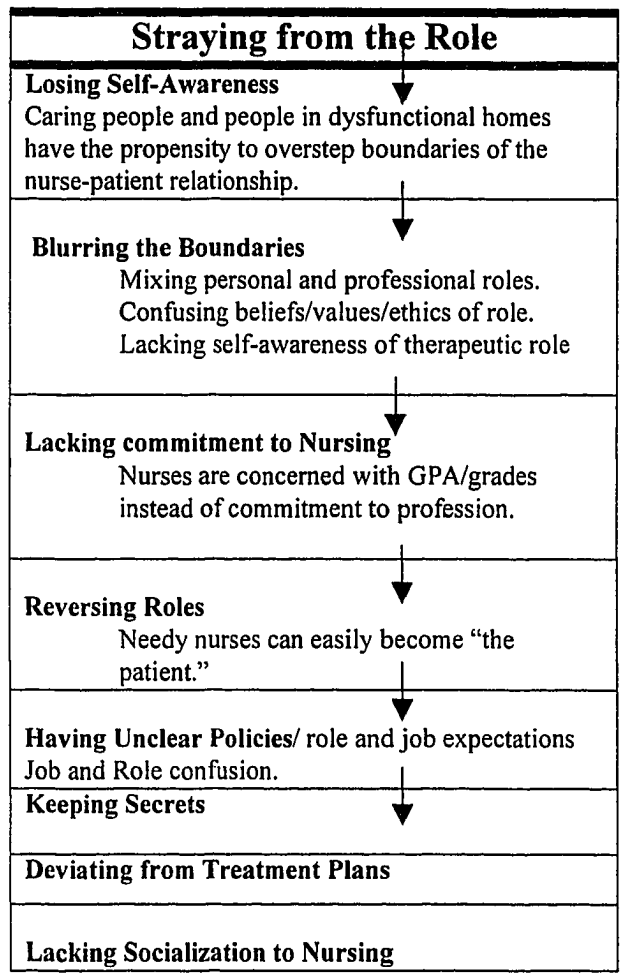
In summary, Stage One, *Being Vulnerable*, initiates the process for the nurse to breach the nurse-patient therapeutic relationship. Five conditions were identified and presented in the first stage: Choosing Nursing, Developing Beliefs/Values and Defining Self, Educating Nurses, Creating Negative Work Environment and Lacking Advancement of the Profession. Each condition was presented as having influence in the susceptibility of the nurse to become vulnerable. Each of the five conditions will be cross-referenced by parenthesis in the second stage *Straying from the Role*, to show the influence and progression to the second stage.

Stage Two: *Straying from the Role*

The second stage in the process of the nurse *Breaching the Nurse-Patient Therapeutic Relationship* continues with *Straying from the Role*. In contrast to Stage One conditions that made the nurse vulnerable to breaching the nurse-patient therapeutic relationship, the conditions in Stage Two have progressed to the point so that the nurse is straying from his/her role. *Straying from the Role* is defined as the nurse leaving the therapeutic realm and engaging in nontherapeutic activities with the patient. The eight conditions in Stage Two are: Losing Self-Awareness, Blurring the Boundaries, Lacking Commitment to Nursing, Reversing Roles, Having Unclear Policies, Keeping Secrets,

Deviating from Treatment Plans, and Lacking Socialization to Nursing. The five conditions from Stage One will be listed in parenthesis corresponding to those of Stage Two to illustrate the progression of Stage One, *Being Vulnerable* to Stage Two, *Straying from the Role*. The eight conditions of Stage Two are found in Figure 4.4.

Figure 4.4 Stage Two



Losing Self-Awareness (Choosing Nursing) addresses that most nurses are caring people and caring people have the propensity to over-step the boundaries of the nurse-patient relationship. Caring people have the tendency to take the "extra step" with

patients and in doing so, they sometimes lose sight of the parameters of the therapeutic relationship.

"...in both the situations that I was involved, which I don't think that either nurse ever set out to harm the patient. They both very clearly told me I was just helping this person. You know we became friends. They didn't have a place to live. You know, blah, blah, blah. Everything could be rationalized." Cookie (965-972).

"My perception of her (nurse who got romantically involved with the husband of the nurse's terminally ill patient) was that she was an exceptional nurse in terms of her warmth and ability to be empathic and really care..." CP (95-97).

"In the case with 2 of the co-workers that crossed boundary situations...both of them were having some traumatic situations in their life at that time that their boundary violations occurred." (one female and one male nurse became romantically involved with patients). Mary (529-533).

CP saw the nurse as extending her role, going beyond the usual emotional involvement that nurses have with patients, perhaps sharing too much.

"I saw her as always taking the time. I saw her as being emotional. When I say emotional I mean both the happy and the sad and that she shared...she shared pleasure and ...she probably did share...now that I think back at it, I'm ... (108-113).

Nurses need to have an awareness of their knowledge base. They need to understand therapeutic relationships but need to be competent to practice nursing.

"I think that also brings up the dual pressure on any healthcare professional not only to empathic and caring but to be knowledgeable. Keep up with the knowledge. I would hope that nursing doesn't slip in that you know in the balance of trying to be too caring. But yes when you are critically or even chronically ill you want someone that knows what they are doing and can pick up on the....and that is where I think a lot of nurses get on each other." Sparks (1448-1458).

There are standards of professional caring behaviors for nurses.

"Well, clearly the caring that you are giving needs to be within the boundaries of the ....work situation. It's too much if you're coming in outside of hours to do things with the client. It's too much if you are interfering ...if there is another shift there working with

the client...and if you are interfering in the relationship that the client should be having with other staff members that are there...you know if you're going way overboard from what's set up with the individualized treatment plan. It's also too much if you're going way beyond what is customary care for the other patients on the unit...." Mary (381-397).

The nurse who lacks awareness of the parameters of caring within the nurse-patient relationship contributes to the nurse straying from the therapeutic role into a nontherapeutic relationship.

Blurring the Boundaries (Developing Beliefs/Values and Defining Self)

There were three areas addressed in Blurring the Boundaries. These are mixing personal and professional roles, confusing beliefs/values, ethics of the role and lacking self-awareness of therapeutic role. First, for some nurses the lines of demarcation between their personal life and professional role was unclear.

"Their whole life was their job and they were not able to break the link between their personal life and their professional life. They knew that they were crossing over but for some reason they weren't able to stop themselves." [Nurses were engaged in sexual relationships with patients.] Cookie (322-327).

"The case I recall is the nurse who was having financial difficulties. She was also a single parent. This patient, who she is married to, provided those needs..." (Patient later murdered the nurse/wife, her children and himself). Sherri (406-410).

"...It was chemical dependency...he borrowed money from patients and then another patient or took this or that from an employee or borrowed lunch money...it took (me) a period of about four weeks to see this pattern...it was clearly chemical dependency (of the nurse)." Yellow (257-268).

"...the nurse got into a friendship relationship and treated the relationship as a friendship rather than as a therapeutic nurse/client relationship...when the supervisor became aware of the relationship (123-128)...the nurse and the patient were observed in the parking lot in a car engaging in sexual behavior...the nurse lost his job." Mary (21-24).

"...I think anything beyond that (being resourceful, supportive, reassuring, giving information) is where you are getting into boundary difficulties...I would say, any personal service, like buying the patient something. Loaning them money. Offering them a ride somewhere. Offering to maybe come out to their house or inviting them over for dinner, that sort of thing outside of the therapeutic setting." Lucky (71-80).

Secondly, the beliefs/values of the nurse can make the nurse vulnerable because the nurse has not developed a sense of self and lacks an understanding of how these impact the therapeutic nurse-patient relationship. These beliefs/values and lack of awareness contributes to *Straying from the Role.*

Further, the nurse was morally/ethically confused about how much helping/caring was needed. The parameters of what constitutes therapeutic helping was interwoven into the nurse's personal values. They began to rationalize behaviors.

"well it was...we (roommate and nurse) had him (patient) over for Christmas and he's a different faith than I am and he doesn't celebrate Christmas, so I kept saying to him that he had to come and see my Christmas tree. He kept saying no and I thought he didn't care about seeing the Christmas tree because he was...he didn't want to leave the hospital without...a group...he was afraid if he fell, there wouldn't be some one to help him. So my roommate and I said we are there...he said ok that he would come over....shortly after that, he became a friend instead of a patient. He gave me a teddy bear for my birthday, which is January..." Blondie (119-136).

"...sometimes their (nurses) needs were gratified but they didn't seem to indicate that there was anything wrong with not spending time with the other patients who were also assigned to them..." Mary (577-581).

"...they (two co-worker nurses who became romantically involved with patients) saw less of a need to hold to a particular standard or why these clients that they were working with – they didn't see as much problems with them having special privileges beyond what other patients had for privileges or why they shouldn't spend hours with one patient while other patients on their team perhaps didn't have any time." Mary (561-569).

The nurse-patient therapeutic relationship boundaries were blurred as a result of the nurse's beliefs/values of what is within the realm of the nursing role.

"...For these individuals (nurses) it was like having their own needs met meant more to them than meeting the needs of all the clients in the agency. It didn't seem like it was wrong to them to engage in this type of behavior." Mary (589-594).

"...the relationship did start on the unit when the patient was an inpatient. The nurse did develop a friendship that went on to develop into a deeper relationship...they wind up getting married..." Lucky (17-21).

"...if you don't have a real good grounding of what therapeutic communication is and where boundaries...what are appropriate boundaries...I would say almost all the cases of where the nurses got into problems...the manager has to come to a very clear understanding with the individual where they are at in understanding therapeutic boundaries. The person has to have some type of knowledge and ...defining their own perception of professional boundaries." Mary (226-260).

Nurses need a strong sense of self and optimal mental health to keep them from straying from the role.

"...I think unless you are really aware of your emotional needs, it would be very easy for some nurses to become involved with patients." Lucky (347-349).

"I think that first of all, they (nurses) need to be very healthy in their mental outlook. They need optimal mental health themselves before they can be therapeutic..." Lucky (353-356).

The third area of Blurring Boundaries, is lacking self-awareness of the therapeutic role. Lacking self awareness is defined as the nurse not having an awareness of when he/she engages in nontherapeutic activities with the patient. If the nurse has unclear boundaries, the lack of self-awareness serves to further complicate the issue. If the nurse is unaware of his/her needs, limitations, strengths, or responsibilities, the nurse may proceed into nontherapeutic roles and never know it.

"If you're not able and willing to recognize your own needs and take care of them, and separate those needs from those of your patient...there is no way that you can be therapeutic." Twigg (661-665).

" I don't see how anyone (nurse) who is needy as that particular individual (nurse who went to work very distraught) could be, in any way, therapeutic to anyone." Twigg (657-659).

"...we, as nurses, have fallen astray when it comes to a work setting with our fellow peers...where we re-evaluate the way we deal with our patients and drawing that line between ourselves and our patients when it comes to our needs being met. You know, where we can sit and talk...we just focus on...ourselves...a re-evaluation." Sherri (704-717).

"Well, as a manger, I find it more difficult for my staff to keep their personal lives at home. They want a therapeutic environment for themselves at work...their significant other relationships are, perhaps, not as strong as they need to be, or their support system, whatever that is. Whatever those mechanisms are...aren't working and so, I end up being a counselor so much of the time." Yellow (718-729).

"...both cases (sexual engagement), the individual nurses had some kind of attraction to the patients and didn't identify the fact that they did...they need to recognize when there is some kind of attraction to a patient...a physical attraction to a patient...and take responsibility not to care for that patient." Branch (328-355).

In summary, the participants emphasized that lack of clarity in the parameters of the nurse-patient relationship and the lack of self-awareness were extremely important factors for a nurse straying from the therapeutic nurse-patient role. The Blurring of Boundaries clearly saw the nurse acting from a lack of self-awareness and a lack of knowledge when engaging in a nontherapeutic relationship with the patient. The nurse lacked insight and awareness of the underlying motivations of his/her behaviors with the patient, as well as clarity in therapeutic nurse-patient role/boundaries.

Lacking Commitment to Nursing

The third condition in Stage Two, *Straying from the Role*, is Lacking Commitment to Nursing (Educating Nurses). Lacking Commitment is defined as a change in the commitment of nurses entering and practicing nursing today as compared to

nurses in the past in terms of commitment to the profession of nursing. This change was attributed to changing societal values as well as educational programs. The religious components of the past are not a part of the educational programs in today's nursing programs.

"...I'm finding out that nurses go into nursing now for different reasons....they don't have the buy in to the profession of nursing. They don't see it as a profession...." Yellow (534-548).

Further, the nursing educational systems have promoted standards of Grade Point Average (GPA) achievements as a benchmark for academic success rather than emphasizing the ethical/moral standards; this has caused a decrease in the commitment to nursing as a profession. The emphasis on upholding the professional standards and the ethical codes of nursing needs to be emphasized because nurses have put their needs before the needs of the patient.

"...I think we've lost a lot of ground with this whole profession in struggling to recruit and to get good nurses...I think a lot could be improved upon if we went back a little way and became a little more traditional...make our profession become more recognized as a profession." Lucy (682-703).

Many nurses are unaware of the American Nurses Association codes of professional conduct; again, illustrating their lack of commitment to the profession.

"I've been teaching an ethics class at another university and I will tell you...I've probably taught 7 or 8 of them at this point and the majority of the students who came to that class do not even know about the ANA's code. It has not ever been introduced to them...so we missed some place. These individuals registered nurses. They are not new grads...or people just coming into a program." Branch (1817-1826).

"I was a nurse for 20 years and it took this incident with the 2 employees for me even to have to go and find out...I did find in the Arizona State Code....that the wording was so vague, that legally....I think we really have to look at this. We have to define it (nurse-

patient boundaries)...we have to get it out to everybody because every nurse should know it and it should be taught in nursing school...." Cookie (1827-1840)..

"Because unfortunately we live in....well, my children go to what we call the "Cumbya School", where there are no rights and wrongs...it's like, "oh well, we'll let him get by with this or let her get by with this and it's okay. No, to me, it's not okay. Those are wrong...we do not have some gray areas....society is unfortunately, the blacks and whites have gotten smaller and smaller and the gray areas has gotten larger and larger. WE need to get back to having more definitions...for our profession...." Prez (1865-1879).

Lacking Commitment to Nursing was a major concern by participants. The minimized commitment to the profession has contributed to nurses engaging in nontherapeutic roles with patients because nurses do not value and adhere to professional conduct standards.

Reversing Roles

The fourth condition of Stage Two, *Straying from the Role*, was identified as Reversing Roles, (Creating Negative Work Environment). Role reversal is a nontherapeutic move by the nurse to move from a "helper" role to that of "helpee" or patient. Role reversal includes the nurse altering the professional therapeutic role to engage in activities with the patient as a friend or patient. The needy, emotionally unstable nurse, who may be from a dysfunctional family environment, who has not been adequately screened for emotional health, can easily become engaged with a patient to get his/her needs met through "role reversal". In role reversal the nurse looks to the patient to solve his/her problems. To illustrate, this distraught nurse disclosed too much personal information to the patient and enlisted the patient to become her advisor/nurse.

"...found that the nurse was apparently involved in a violent relationship and had been abused the day before she came to work and feeling this bond already developing with this elderly, motherly type of patient she started to cry a little as she was working with her and the patient quickly picked up on it and said, what's wrong with you tonight?

What's going on? The nurse had unfolded this whole horror story of what had happened in her day. Events that lead up to it and how distressed she was and the patient even went as far as to say maybe you shouldn't return to work." Lucy (582-596).

Nurses in personal abusive family relationships may be ashamed to share this personal experience with coworkers. In vulnerable moments, however, one nurse engaged in role-reversal with a kind, motherly patient. The relationship was a secret.

"I believe in my experience that the nurse had probably been in this relationship with the situation for some time and had been able to come to work and do her job and this is not unusual. There is a lot of secrecy and they don't divulge the situation. In this particular time I think she was starting to realize that it was getting really bad and that she needed help and I think that this patient touched her at a very vulnerable moment. It wasn't a person that routinely would have come to work if they didn't feel capable. I think it was just a vulnerability at that time." Lucy (923-936).

Having Unclear Agency Policies (Creating Negative Work Environment).

The fifth condition for contributing to the nurse *Straying from the Role* is Having Unclear Policies. Having Unclear Policies is defined as the lack of policies that define the role expectations of the nurse. Nurses, like all professionals, need standards of practice or functional statements about jobs/roles that spell out performance expectations.

"It seems to me like employers are responsible for the patient care that is given. I mean that is so obvious. When a patient is admitted to an institution or facility of any kind they are responsible for the care that is provided. Therefore it would seem to me that they should be held responsible if their employers are not providing that care which equates to therapeutic relationship as well as the technical kinds of skills." Branch (2072-2081).

Without these standards, boundaries can be crossed and roles can easily be reversed. When employing agencies failed to provide structure or guidance, it sets the stage for role reversal. Nurses can be viewed not as professionals whose primary purpose is caregiver but in other roles such as girlfriend, lover or someone in need (patient).

Participants expressed concerns about the lack of policies that defined the professional appearance of the nurse because they believed appearance was critical to a professional image.

"...but we are in a such being a politically correct society we can't even get an HR department of a large federal agency to allow us to have a dress code so that we can tell people what is OK and not OK to wear to work. So how can we ever go about and define what is ethically correct?" Cookie (1858-1864).

"...we talk about civil rights and not really dwell in deeply in the real issue. What is professional? What isn't professional? Because our patients do look up to us, how we present ourselves does make an initial impression and lasting impression on our patient. Or vice versa, you the patient and the patient, the nurse. Any way that you look at it. The first impression can be very lasting." Sherri (1884-1893).
"One of the cases that I was involved with, one of the nurses involved continually wore what I considered rather provocative clothing. Very tight shirts and pants and it would be fine if it was going out dancing but I didn't think it was the right thing to be wearing to work. But in talking...I had absolutely no legal right to address what she was wearing because there was no dress code and I was not allowed to make a dress code. Now I have to tell you that when I was a student nurse, I was sent home one day because my head nurse did not like what I had on. I had to go home....No, she let me stay but she said that I was never to wear that to work again. I didn't think it was so bad but you can sure bet that I didn't wear it again. But in this day and age, I was not allowed to address that issue with the staff nurse that I was working with." Cookie (1925-1944).

This lack of policy/guidelines caused confusion about appearance in that some nurses were accused of dressing up "too much" for the work setting.

"...well back in the Midwest, we would wear suits, or dress or a nice pantsuit and I can't tell you how many times I was pulled in by my supervisor to tell me that I was too dressed up. But yet, I was there....I was the professional and if I was out in the community I needed to look professional and that's just the way in my beliefs of where I needed to be, yet I was talked to about that." Prez (1949-1958).

Further, basic cleanliness was viewed to be elementary to professional appearance that was not necessarily valued by all nurses.

"Combing hair is important. Washing the hair and cleaning the nails is important if you

are going to touch a patient, I'm sorry." Cookie (2007-2009).

"But we are running up a new generation to whom those things are not necessarily important. So how do we accomplish what we are after as far as professional behavior." Twigg (2010-2013).

In addition to appearance guidelines, nurses need policies on ethical behaviors in the nurse-patient relationship for therapeutic and legal purposes.

"...we at least need to some how write up some kind of a brief little, ethical or moral standard to help them better understand what they can or cannot do and help them define it. I think that is really hard... I do think there are things that are professional, we may want to work toward. A simple dress code. Having to do with cleanliness. Having maybe to do with in some mental health areas. Appropriate dress and maybe we could even say something as even non-provocative you know I think those are the kind of issues led people down a different kind of path that they should have gone. In the instances that I was involved in, and I have to say that professionally, if I saw some of the nurses that I work with coming to take care of my father I can't tell if they are an RN or a nursing assistant or what they are, I would ask them to wash their hands; and I don't know how you can do patient care with 3 inch long nails. I just don't get that. But that is just me....I don't understand how you can do patient care like that. Those are issues that we are going to have to continue to look at." Cookie (2027-2055).

As part of defining the parameters of the nurse-patient relationship, nurses need definitions of when is a patient no longer a patient. The standards and policies need to define the parameters of nurse-patient therapeutic relationships to prevent therapeutic role deviations.

"I just think that one other thing that we have define, because when we talk about litigiousness, and talk about patient care as identified and what happens in the institution. I know the two cases that I'm involved with and I believe that one that ____ was involved in...when does this patient cease being a patient and do you have any kind of ethical responsibility or does an institution maintain any responsibility for relationships that develop out of an initial meeting in a hospital setting. I think in the olden days....World War II nurses married their patients. They met somebody in a hospital and married the patient. That was OK behavior. But is it different now in a med/surg setting. Is it OK for a nurse now to marry her patient that she meets in a med/surg setting and should there be different standards in a psychiatric setting where

many times the therapeutic environment continues outside of the initial inpatient stay. So those are questions we have to look at." Cookie (2097-2121).

Participants agreed that there are institutional and professional expectations that a certain amount of caring and helpfulness by a nurse is therapeutic. The problem was to define how much caring and helping the patient is therapeutic and to define it in an agency policy.

"I don't know how to measure that. I think it's an unmeasurable thing. I think it depends on the nurse. I think it depends on the clinical setting that you are in. I think sometimes those lines are easier drawn, potentially in a medical/surgical kind of setting versus a psychiatric or a substance abuse kind of setting. I don't know a way to measure that so I can't answer that any better than that." Cookie (73-82).

"I don't think it's a matter of how much caring or how much helping. How much does that particular client need? How much help does the client need to become as well as he or she can become? I think sometimes we feel that we are more responsible for the caring of a patient than is really helpful to the patient." Twigg (92-99).

Culture was also identified as a factor in determining how much caring/helping by a nurse is therapeutic. Caring/helping is different in some cultures.

"...I think that the big thing that we have to look at is the cultural differences and make sure that we don't cross boundaries just by going into an area that might not be therapeutic from a cultural standpoint to your patient – even though it might be, within your culture." Lucy (100-106).

The context of the clinical setting in which the nurse is working also determines the parameters of how much helping, caring is appropriate.

"I think that you need to look at the settings that you are at; what is acceptable in a hospital versus what is acceptable in a families home is very, very different. I think one of the boundaries that really stands out is when professionalism versus friendship gets in the way. Establishing that guideline can be very difficult because as nurses, we want to be helpful....I think that we need, as nurses, to look at and talk to our patients...present options and have them make their own decisions...sometimes we tend to take on too much responsibility..." Prez (107-121).

"...I think part of it is helping the patient to identify what their needs are and then going from that place rather than the nurse identifying what the patient's needs are..." Branch (149-153).

"And that is true until you come to critical care and peri-anesthesia when the patient can't make decisions..." Yellow (156-158).

Another need for having clear policies was to clarify when the nurse might foster patient dependency while thinking he/she is operating in a caring/helping therapeutic role.

"...my situation is a little different...I don't do the episodic, brief in hospital type care. It's chronic long-term. They are my patients and I can't pass them over to someone else. I think that is a real challenge for dependency needs for patients. When you follow someone for years – they can become very dependent on you....I think the key word for me is when you realize that the patient is becoming dependent on you...you have to work on some boundaries here." Sparks (205-223).

The infinite parameters of the nurse's role makes it extremely difficult to provide such guidelines in a definitive manner but the rules of conduct, ethics in practice and standards addressing competency provided some guidance in practice. Some nurses relied on a "gut feeling" to help know when the nurse was stepping out of a therapeutic role.

"I think as nurses, you do get a gut feeling..." Sherri (224).

Others believed the nurse should know the role expectation of the professional nurse was to set the limits with patients.

"...we have to help nurses recognize that they are the ones who are setting the boundaries..." Branch (233-236).

There were other contributing factors within the work environment that encouraged conflicting/confusing messages about the nurse's role from expectations of

others. A powerful force, the physician, was such a contributing factor in influencing some nurses to engage in nontherapeutic relationships with his patients.

"...they were even almost set up or encouraged by the physician who was the attending physician ...the physician wanted his patients to have special privileges and special treatment compared to what the other patients who were being treated there at that time. Especially wanted his patients to have more time spent with them. To not have his patients follow the same kind of guidelines for the particular unit that the other patients would follow or what the guidelines for the unit were." Mary (28-43).

The work environment, through its conflicting expectations of the nurse being a social agent to the patient, contributed to the role confusion. It's easy to alter the therapeutic role when one is encouraged to behave as a friend.

"...we were encouraged to do that. We were encouraged to accompany these patients (on trips) at least once a week...at least very minimum would be twice a month..." Blondie (39-) "...and I still don't think I did anything wrong except I should have been aware of the policies of the institution." Blondie (511-515).

"...I think the hospital should have never encouraged staff to...we were set up. You're told that you need to do this and you have people with no money (the nurses) and you are throwing these tickets for museums and Broadway plays and stuff. I think that the policy of non fraternization with patients....we were never even told there was a policy that said you couldn't date patients." Blondie(532-543).

In summary, although the work environment does not have policies, there are some established guidelines on nurse-patient relationships, and these are from the profession of nursing.

"The National Council of Nursing actually address when it is appropriate to have a personal relationship with a patient...and we know that...they have a number of pamphlets about boundaries..." Branch (2122-2126).

The conclusion in Having Unclear Agency Policies was that nurses need the guidelines, standards and policies to clearly define role expectations and limits of the

therapeutic role. The lack of policies on dress/appearance contributed to sloven and inappropriate appearance of nurses, even to the point of over dressing.

Keeping Secrets (Creating Negative Work Environment)

This is defined as the nurse not discussing openly his/her actions with a patient, and in fact, avoiding such discussions. Secrets are counter-productive. The nurses involved in nontherapeutic relationships with patients kept the relationship a secret from co-workers. The fact that it was kept secret, and the actions of the nurse were not written or discussed as part of the treatment plan, suggested that the involved nurses deemed the relationship to be an unacceptable mode of action.

" I think one of the important things as I look back on the two cases that I was involved with. It was a secret. I think somewhere these nurses involved knew that it wasn't the right thing to do because it was a secret. They wouldn't talk about it. One thing that Twigg and Sherri have both said and it seems to me that this is an identifiable thing that we can say to people is that if you can't put it on a treatment plan, if you're intervention with this patient is not something that you are willing to write down to have other people do also then you probably crossed the line." Cookie (449-462).

Secrets lead to a change in power and control structure of the nurse-patient relationship.

"...it was not a therapeutic relationship when you are moving into that special relationship. Because then, you are in an unequal relationship. You know when you're participating in that social relationship, but you have been the nurse with that patient, you clearly have some power over that patient...you have knowledge over their circumstances and that puts you in a power relationship; but on the other hand, if part of that relationship is secret, that client has power over the nurse in being able to use it...kind of threatening...when you've crossed over that, there is a secret. There is a secret going on..." Mary (89-106).

"I think that the nurse ceases to be therapeutic ...when secrets are involved..." Mary (201-203).

In summary, it was determined by participants that keeping secrets, particularly secrets of the nurse-patient interactions, lead to the nurse *Straying from the Role*. When compounded with a nurse who has lost self-awareness and has blurred boundaries, this nurse is prone to moving into a nontherapeutic relationship with the patient.

Deviating from Treatment Plan (Creating Negative Work Environment) is the seventh area of *Straying from the Role*. It is defined as the nurse making exceptions to the treatment plan or not documenting nursing care actions as part of the plan. Actions that cannot be written or are not written into a treatment plan, are highly questionable, because the plan is the legal document of the plan of care. Participants identified that the treatment plan of the patient is the focal point for defining the nurses relationship with the patient as therapeutic or nontherapeutic and a way of communication among nurses and other health care professionals about what we are doing for or with a patient. When actions are not documented on the treatment plan and are observed by others, in a great majority of cases, the actions were nontherapeutic.

"I would just say one other thing with that....In the two cases that I was talking about, I don't think it was part of the treatment. It was just something that happened. So that is where the idea that you have to have a plan if you're faced with it. Because there wasn't any treatment plan. Backrubs, massages were not part of the treatment plan." Branch (463-471).

Deviations from treatment care plans, even in home health settings, promote secrets and nontherapeutic activities if the nurse is inclined to alter the nurse-patient relationship by treading into blurred boundary roles.

"I know that looking at the setting in the home when you're taking care of a child in the home, you talk with your nurses. The home is the families. How do you prepare a nurse

for a dad coming out of the bedroom in his underwear to go to the kitchen to get a glass of milk. I mean those are things that we do need to prepare them for. In my particular situation that I'm going to speaking about is where there was a child who was ventilator dependent. There were a lot of family stresses as happens when a child who is ventilator dependent. Parents were paring against one another. Nurses were unfortunately taking sides. Some nurses were telling one parent "Well you should look at getting a divorce". I'm sorry that is where you've really cross the line. That is something that you can't put in a treatment plan and that also in that particular case because it was a grant that was funded by the Federal Government we were looking at nursing hours and I also had another nurse in the same family say "Well one way to get more nursing hours is to go ahead and get pregnant again." By having more children they'll have to give you more nursing hours." That also was kept a secret from me then through the grapevine I heard about it and that's again, if you are able to put it on a treatment plan, if you're keeping any kind of secrets, if something is coming through the grapevine to a supervisor and/or the administrator you've crossed the line." Prez (472-508).

To remain in a therapeutic role, it is necessary for the nurse to communicate what he/she is doing to help the patient with all members of the treatment plan.

"...I handle it from the professional point of view. Not that I'm stepping the boundary but this patient would acknowledge and share with the other staff when anything is done for that individual patient that makes him more comfortable. Not just myself but with all the staff. This is where you share with your peers what you are doing and they do similar for that patient because not only that was identifying what I did but also identifying what my peers did. That is why it's important that we communicate. We have a treatment plan. We know what we are doing for our patients and so no individual staff is singled out as the special nurse." Sherri (1382-1397).

Through communication, it becomes clear when nurses got singled out as a special nurse for a particular patient. These "special nurses" are more vulnerable to straying from the role as they make exceptions for complimentary patients. A good question to ask, anytime the nurse makes exceptions to unit rules, or deviates from a defined treatment plan, is "who's needs are being met – the nurse or the patient?" The participants identified this intervention as an effective aide to maintain adherence to the established plan of care.

"...sharing what you know about this patient or your plans for this patient with your fellow nurses so that you are not singled out as the only person who can deal with the situation or care for that individual." Sherri (87-91).
"...I think it's important not to be the nurse for that client. To have a well defined care plan that of course is subject to changes but it gives you a structure and guidelines for the care that you are going to give and to make sure that other nurses on other shifts are just as involved in the care of that patient. It also helps you to get feedback about are you going too far. Are you meeting your needs instead of the patient's needs." Twigg (194-204).

"I think it's hard....to be objective about our own behavior, own motivation. I think it's so important to have a plan and to share that plan with our co-workers because we can hear ourselves and understand ourselves in our process of interacting with our peers and we can't always so that just going around in our own heads." Twigg (384-392).

"Too little (caring) is when you are not meeting the care that is indicated by the treatment plan...too little is if you refuse or didn't try, ignore working with the client...not meeting the individual needs." Mary (408-422).

In summary, Deviating from the Treatment Plan facilitates *the Straying from the Role*. If actions can't be documented in a treatment plan, these actions are not likely to be therapeutic. Deviating from the treatment plan should be a red flag to nurses that the involved nurse may be moving from a therapeutic to a nontherapeutic nurse-patient relationship.

Lacking Socialization to Nursing (Lacking Advancement of the Profession) to nursing is the eighth area of Stage Two, *Straying from the Role*. It is defined as the lack of the integration of the professional values within the nurse.

Nurses are educated, not socialized, into nursing and this lessens the "buy in" to the profession of nursing according to most participants.

"I know a lot of people don't like to hear the word socialization but we are not socializing nurses into nursing anymore. We are educating them. We are hiring them. We are orienting them. We are putting them to work. But there is no socialization.

There is no "buy in" to the program." Branch (2018-2024).

"...too much we talk about civil rights and not really dwell in deeply into the real issue. What is professional? What isn't professional?" Sherri (1883-1886).

One aspect of Lacking Socialization to Nursing is that it prevents Commitment to the Profession. It is through the process of socialization into nursing that the values, the pride, the sense of responsibility to patients and to the profession becomes internalized within the individual nurse. Socialization encompasses more than education; it involves integrating attributes, morals, attitudes.

"...we are not socializing nurses into nursing anymore. We are educating them. We are hiring them. We are orienting them and we are putting them to work, but there is no socialization. There is no buy in to the profession...." Branch (2019-2024).

The progression of Lacking Socialization to Nursing in Stage Two was manifested in Stage One as Lacking Advancement of the Profession. It was felt by many of the participants that the profession of nursing has not done enough to promote the profession. Many aspects that contribute toward advancing the profession were discussed, particularly salary and role salience of the nurse. The commitment to the profession itself is affected by whether the profession has prestige (advancement) and whether members have been socialized adequately into the profession. Furthermore, nurse-patient relationships are influenced by many other factors that were attributed to commitment to the professional role of nursing. When the topic of committing to the profession of nursing was discussed, socialization into nursing and nursing salaries were emphasized as significant factors. Initially all participants stated that salary was not an influencing factor in the nurse maintaining a therapeutic nurse-patient relationship.

However, as the experienced nurses examined the commitment level to the profession and the standards of practice by new nurses, nursing salaries evolved as a hallmark of symbolism for credibility to the profession. Some salient features connected to nursing salaries were enhancement of job satisfaction, which also made the profession more attractive and provided financial stability. If the nurse has financial security, it lessened the nurse's need to seek financial assistance from other sources, such as gifts from the patient. Lastly and equally important, is that there is a positive esteem factor for the nurse if salience to the role of the bedside nurse is recognized with a commensurate salary.

Some participants stated that bedside nursing has lost its appeal. Technology (computers) keeps the nurse from the patient and changes the nature of the nurse-patient relationship to one of the nurse being distant, aloof and on the end of the continuum of being under-involved. This lessens the role satisfaction for many nurses.

"...it's not that we have a nursing shortage; it's that we have an unwillingness of our nurses to get back at the bedside or even go there in the first place to care for people. We have to make it more appealing for them to do that. Whatever that is going to take." Yellow (1627-1633).

"...it's a lot of advancement with a computer but my assessment of it was, it was taking at least 40% of the bedside nursing. The reason...if I could do a paper on it, I would...because I speak to so many nurses, even now that I am retired. Deep down, they want to be caring. They want to spend that time. Not from crossing the boundary but providing the needs that are necessary for that patient up for care; but they cannot give it because so much is spent on the computer. I really feel that maybe it needs more staffing. Who know? So that they can spread themselves more evenly." Sherri (1640-1652).

Nurse-patient relationships are also adversely affected if the nurse lacks job satisfaction. There is a lack of commitment when the job does not have an adequate

salary.

"...it would be great if money wasn't everything but ...money does put food on the table...as nurses, you need, also, to focus in on satisfaction and other things that are involved with the nurse-patient relationship.' Prez (1670-1678).

"...money talks." Sherri (1685).

"...the new nurses coming now, they are moving along and they are going where they can make money..." Sherri (1681-1684).

"...they (new nurses) are looking for financial stability...they are not giving it (nursing profession) *the professionalism that they should..."* Sherri (1699-1704).

Nursing salaries remain lower on the scale than the salaries of many of the nurses children. Additionally, because nursing salaries are low, there is less salience to the role, less commitment to the profession to keep the professional image pure. Nursing cannot be made attractive without an attractive salary.

"What I think it (money) would do is, it (salary) would produce some stability for....there are some nurses like you said earlier Yellow is that go into it (nursing) because they are looking for financial stability. I mean it's not a big stability but it's some. They are not giving it (nursing) the professionalism that they should. So I think that if you boil it down, money does contribute some to it." Sherri (1696-1704).

"...money is needed in every career and in life in general..." Sherri (1616-1617).

"If you're talking about what the nurse needs to have in order to be therapeutic to her patients then obviously if I feel like I can pay my bills and my kids have their lunch money, I'm going to feel better about myself and therefore I'm going to feel better about my job..." Twigg (1709-1715).

Another factor, professional appearance, was addressed at length and some participants felt the unkempt appearance of nurses contributed to Creating Negative Work Environment and Lacking Advancement of the Profession in Stage One and Stage Two. The profession of nursing has not specifically addressed dress code standards and

employing agencies have not always provided, or even permitted, a dress code policy. The appearance of professional nurses makes a statement reflective of the work environment and the profession; it can be a negative or positive statement.

Summary

In Summary, Stage Two, *Straying from the Role*, was presented in this section. The eight conditions in Stage Two are a progression from the five conditions in Stage One (see Figure 4.2). A nurse becomes vulnerable in Stage One to stray from the therapeutic nurse-patient relationship in Stage Two. The conditions in Stage Two that lend to the nurse straying from the therapeutic nurse-patient relationship are Losing Self-Awareness, Blurring the Boundaries, Lacking Commitment to Nursing, Reversing Roles, Having Unclear Policies/Role and Job Expectations, Keeping Secrets, Deviating from Treatment Plans, and Lacking Socialization to Nursing Profession. The twelve participants discussed the situations in which the professional nurse engaged in nontherapeutic relationships with patients. In Stage Two, Losing Awareness, the nurse, who was altruistic or egotist, over-stepped the boundaries of the nurse-patient relationship and engaged in a nontherapeutic relationship with the patient. In Blurring the Boundaries, the nurse has not developed a clear sense of boundaries; the ethics/morals of the nurse was blurred. Another condition in Stage Two, Lacking Self-Awareness of the Therapeutic Role, the nurses engaged in nontherapeutic relationships because they lacked self-awareness of boundary and therapeutic relationship parameters. The nurses were unclear as to the difference between social and therapeutic roles. The third area in

Straying from the Role in Stage Two, Lacking Commitment to Nursing showed that nurses today are less committed to nursing as a profession, which was felt to be secondary to the educational process. The educational focus today is geared more to student grades and less to integrating and internalizing professional nursing values. Nurses who lacked the desired level of commitment to the profession had engaged in nontherapeutic relationships with patients. The fourth condition in Stage Two, Reversing Roles, presented nurses with unmet personal needs engaging in nontherapeutic roles with patients. The fifth condition, Having Unclear Agency Policies, was a contributing factor for nurses to be confused about role expectations and subsequently, some nurses engaged in nontherapeutic (social/sexual/financial) relationships with patients. Keeping Secrets, the sixth condition in *Straying from the Role*, was a continuation of the process. The nurses kept the nontherapeutic aspect of the nurse-patient relationships a secret. The seventh condition, Deviating from Treatment Plans, clearly indicated that the actions taken by the nurse, which were not entered into the treatment plan, were nontherapeutic. The last condition in Lacking Socialization to the Nursing Profession, was the eighth condition in Stage Two. Nurses who are not socialized into the profession lack dedication to the professional role and engaged in nontherapeutic roles. Other salient features for a nurse engaging in nontherapeutic activities were low nursing salaries, lack of job satisfaction and low salience attributed to the role of nursing. Additionally, unkempt professional appearance served as a manifestation of the lack of socialization and commitment to the profession. Stage Two is the heart of the three stage process and

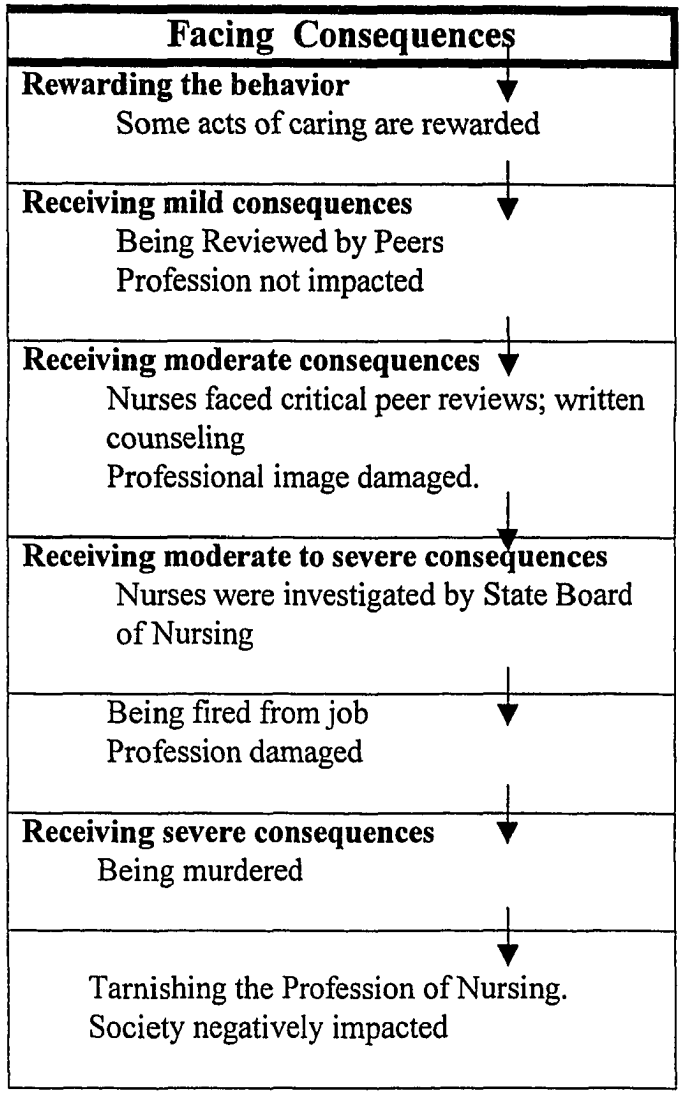
it sets the tone for the last stage of the process, *Facing the Consequences.*

Stage Three: *Facing the Consequences*

Stage Three is the last stage of the process of *Breaching the Nurse-Patient Therapeutic Relationship.* In Stage Three, *Facing the Consequences*, the nurse who had strayed from the therapeutic role in Stage Two had personal consequences ranging from being rewarded, to mild consequences, to moderate consequences, and finally, to severe consequences. In addition to facing personal consequences by the nurse, the profession had consequences as well.

Each level of consequence will be discussed with data to illustrate that there were consequences when the nurse engaged in a nontherapeutic role with the patient. (see Figure 4.5). Included are data about the consequences which tarnish the positive image of the nurse, the profession of nursing as well as the negative impact to society.

Figure 4.5 Stage Three



Rewarding the Behavior

When some nurses moved from a therapeutic relationship to a nontherapeutic one, they were sometimes ignored for the behavior by their peers and work environments or sometimes rewarded for "taking the extra step". For example, one nurse engaged in a social/romantic relationship with her patient and has spent years in a happy and fulfilling

marriage.

"...once he was discharged, it worked out well...He was discharged and then we just continued the relationship because by now, I had really fallen in love with him and he had fallen in love with me. Let's see, that was in '69 and we got married in '72. We've been married ever since" (29 years). Blondie (223-229).

In this circumstance, there is no negative consequence. However, it could be used by others in the profession to justify the behavior of the nurse.

Receiving Mild Consequences

Mild consequences are defined as nontherapeutic acts by a nurse that went undetected for the most part. Noncaring, distant, aloof and cold behaviors of a nontherapeutic nurse often comprised the category of receiving mild consequence. The patient was negatively impacted but that was too often the extent of the consequence. In facing consequences, many times the mild deviations in maintaining a therapeutic nurse-patient relationship were never detected or reported by supervisors but received disapproval from patients and peers. Such was the case from one participant, a nurse manager, who was also a patient. This experience also represented the under-involvement end of the continuum of the therapeutic nurse-patient relationship.

"...the travelers (per diem nurses) were on at night and it got so....many many minutes for them to answer my call light...as a nurse (hospitalized with pulmonary embolism) I knew what could happen to me. I prayed. I looked out my window a lot and I prayed because I was very fearful..." Yellow (1429-1439).

Another example on the under-involvement continuum was from one participant's personal experience with her hospitalized father.

"...my experience was with a nurse who was absolutely not available. Not therapeutic at all in the situation...." Sparks (513-516).

A different example of a mild consequence was identified as the nurse wanting to hold on to the nurse-patient relationship. *"...so that is where I often see a nurse becoming so involved with a family and it's a little more difficult to let go sometimes...." Yellow (170-173).*

The consequence was disapproval from peers to state that the nurse had become somewhat overly involved with the patient but the involvement caused no harm.

In the above examples, these were mild consequences faced by the nurse. The patients were, unfortunately, the ones who faced more negative consequences. The other parties experiencing negative consequential effects were the employing agency and the reputation of the nursing profession.

Nurses who breached the nurse-patient therapeutic relationship faced mild negative consequences from peer review. Peer feedback, particularly the critical (but helpful) feedback to point out peer observations of nontherapeutic behavior was viewed as extremely helpful by participants but determined it could be considered unfavorable by the nurse who was reviewed. The peer review forums offered at some institutions helped some nurses who were at the early stage of breaching the nurse-patient relationship. One nurse was spending extra time with select patients, another nurse was experiencing some physical/sexual attraction toward the patient while another nurse was letting some rules "slip" for a particular patient. Other mild consequences included supervisory intervention, such as verbal caution. For most, the caution was sufficient to modify some early behaviors of the nurse engaging in a nontherapeutic relationship with a patient. Participants believed early interventions by a peer could heighten a nurse's

awareness of nontherapeutic behaviors and provide some self-awareness growth. Self-awareness was viewed as a learned process and emphasized to be essential for the nurse.

"I think it is hard...to be objective about our own behavior, own motivation. I think it is so important to have a plan and to share that plan with our co-workers because we can hear ourselves and understand ourselves in our process of interacting with our peers and we can't always do that just going around in our own heads..." Twigg (384-392).

"I would say being empathic and yet at the same time, knowing when not to get too personal and meeting the patient's needs – whether it's psychiatric or medical. Also, sharing what you know about this patient or your plans for this patient with your fellow nurses...." Sherri (83-91).

"I think it is important not to be the nurse for the client. To have a well defined care plan...It also helps you to get feedback about are you going to far. Are you meeting your needs instead of the patient's needs?" Twigg (194-204).

While peer review and verbal caution was considered to be a mild consequence, the progression to be reviewed by the nurse's supervisors was reserved for moderate consequences. In summary, in mild consequences, it seems personal consequences are faced more by the nurse and patients than consequences for the profession as a whole.

Receiving Moderate Consequences

Moderate consequences are defined as more intense critical peer reviews and written or verbal counselings from the supervisor for more serious deviations in the nurse-patient relationship. Role reversal was one example offered in Stage Two of a moderate consequence whereby the nurse was counseled for deviating from the therapeutic role and transgressing into a patient role. Other moderate consequences included more intense sessions of peer review and supervisory counseling sessions, as when the nurse borrowed money from patients, when some nurses were becoming

romantically involved with patients and when nurses deviated from the treatment plan to make exceptions for select patients. The moderate consequences were viewed to be facing critical peer reviews, receiving written counseling from the supervisor, but not severe enough to progress to the point of losing the job or having a Board of Nursing investigation. Sometimes a nurse was re-assigned to another unit as a moderate consequence.

" ...so she (director of nursing) calls me in and she says, 'I understand you've been seeing this guy and it's not approved and you're being reassigned to another floor'." (Blondie (209-212).

Damaging the professional image of the nurse is the moderate consequence faced by the profession when a nurse engages in such nontherapeutic acts as role reversal, borrows money or other such behaviors in which the patient has partially consented. However, nurses have more power and responsibility than patients so the profession is tarnished by the nurse not adhering to the professional standards. Patients and society are negatively impacted.

"...what is professional? What isn't professional – because our patients do look up to us...How we present ourselves does make an initial impression...." Sherri (1885-1889).

"But we are running up a new generation to whom those things (looking professional) are not necessarily important. So how so we accomplish what we are after as far as professional behavior?..." Twigg (2010-2013).

"...there is no "buy in" to the profession..." Branch (2023-2024).

Receiving Moderate to Severe Consequences

Moderate to severe consequences are defined as being investigated by the State Board of Nursing or by the employing agency.

"...you as a co-worker have an obligation, not just to yourself or to that nurse...to personally meet with that nurse (who breached the nurse-patient therapeutic role). Sherri (272-276).

"...the two situations I was involved with...(female nurses accused of having sex with male patients) Cookie (296).

"...the two situations ....(male nurses having sex with female patients who were investigated by the Board of Nursing) Branch (328-329).

"...he borrowed money from patients..." Yellow (257-258).

Receiving Severe Consequence

Personal severe consequences are defined as more severe consequences at the level of being fired from the job or losing ones nursing license. In most agencies, such acts that warrant severe consequences get reported to the State Board of Nursing. In the Federal agency however, there was a different protocol followed but the outcome was the same; both nurses were terminated from their jobs.

"...the experience that I will be discussing will be as a supervisor in a psychiatric unit...it involved two different nurses who got involved sexually with patients that they were treating." Cookie (19-25) Both female nurses were investigated and fired.

"...I will be discussing situations that have been investigated and dealt with through the regulatory process" Branch (27-29).
"...two situations involved male nurses...lead to sexual misconduct." Branch (328).
"...a nurse appeared before the board (of nursing) in another state because a complaint had been filed that she (nurse) had abused an elderly patient in a nursing home...had slapped the patient in the face...Branch (869-904). (nurse was investigated by board and held accountable...fired).

"...in some cases you could lose your license because you've engaged in something that is a definite violation of the nurse practice act; it could mean some kind of a disciplinary from the nurse practice act...." Mary (706-711).

In summary, receiving moderate consequences to moderately severe consequences

as personal consequences for the nurse to face included being investigated by the State Boards of Nursing and employing agencies, on to being fired from the job. For the profession, the consequence was the image of nursing being tarnished more critically. The profession losses credibility when individual nurses engage in acts that exploit patients.

Facing the Most Severe Consequence

Being murdered was the most severe consequence. The tragic death of an evening nurse was the most severe consequence of a nurse breaching the nurse-patient relationship. The nurse became romantically involved with her psychiatric patient, married him and kept the relationship a secret until the patient murdered the nurse. The negative consequences of the tragedy were experienced by peers, employing agency and profession of nursing.

"In the case that I can recall, this nurse was meeting her financial needs...seemed caring...this patient who she is married to...but the ultimate was that he killed her...killed her children...then killed himself..." Sherri (2147-2158).

"...so it was quite a shock...her (nurse) son. Her (nurse) 2 or 3 grandchildren, herself (nurse) and of course, her husband..." (all shot by patient/husband) Lucky (42-46).

This severe consequence impacted the lives of many people including the nurse's family, neighbors, friends and co-workers. The consequence to the profession was very damaging as the event was highly publicized on television and in the newspaper. The profession of nursing was tarnished with the event. Nursing, as a profession, seeks to monitor and prevent such tragic outcomes. When the nurse, any nurse, engages in a relationship with a patient that is not therapeutic for the patient, the salience to the role of

a professional nurse is diminished. Nursing has defined the profession to be one that protects, assists and cares for members of society in terms of health care needs. Any event, even one event, has a negative impact to the image of the nurse, the profession and subsequently, to society.

Summary

The last stage, *Facing Consequences*, in Stage Three addressed consequences to the nurse and the profession of nursing. The levels of consequences faced were presented from a progressive range of being rewarded on to mild to moderate to severe consequences. Each level of consequence was illustrated with examples from the twelve participants. The nurse who had breached the nurse-patient relationship was discussed in the context of the nurse facing the consequences, as well as how the professional image of the nurse was damaged; this in turn damaged the profession of nursing through the image being tarnished.

Summary of Chapter Four

Results for this qualitative grounded theory study were presented in this chapter. The core concept, *Breaching the Nurse-Patient Therapeutic Relationship*, was a three stage process. Participant characteristics were presented in the first section. The second section summarized the results of the grounded theory.

Stage One, *Being Vulnerable*, was determined to have five conditions for the nurse being vulnerable: Choosing Nursing, Developing Beliefs/Values and Defining Self, Educating Nurses, Creating Negative Work Environment and Lacking Advancement of

the Profession. In Stage Two, *Straying From the Role*, the five conditions of Stage one were cross-referenced to illustrate the continuation of the process from the nurse being vulnerable to engaging in a nontherapeutic role (*Straying from the Role*) with the patient. There were eight conditions identified in Stage Two. The Third Stage, *Facing the Consequences*, was the final stage and presented evidence that there are consequences when the nurse participates in *Breaching the Nurse-Patient Therapeutic Relationship*. In the next chapter, discussion and recommendations of the study will be presented and will include implications for nursing theory, implications for nursing research and implications for nursing practice.

CHAPTER FIVE

DISCUSSION AND RECOMMENDATIONS

In this chapter, interpretations of the study results and integration with the literature will be presented. Additionally, implications for nursing theory, research, and practice will be addressed. Recommendations and a summary conclude Chapter Five.

The core category, *Breaching the Nurse-Patient Relationship*, presented in Chapter Four, is a three stage process. Stage One, *Being Vulnerable*, identified five conditions that made the nurse susceptible to breaching the nurse-patient relationship. Choosing Nursing, the first condition, explained how the nursing profession itself attracts two types of people. Altruistic people are those who want to help others; they have ethical standards and morals and are people who care about others. In contrast, the profession also attracts another type, egotist. Egotist are those who are looking to meet some unfulfilled personal needs. The egotist often includes people who are from abusive and dysfunctional families/environments.

The second condition in *Being Vulnerable* was Developing Beliefs/Values and Defining Self, and provided credence that these contribute toward breaching the nurse-patient therapeutic relationship. In other words, nurses act on their established beliefs and values. If the nurse has an unclear definition of self (sense of self) and personal boundaries, the values of the nurse are blurred in terms of nurse-patient relationships. The value system of the nurse is faulty when discerning the differences between being a friend to the patient and being a nurse. If the nurse believes he/she should act as a friend to the

patient, while ignoring rules, policies and treatment plans, because it is the nurse's firm belief that what the patient needs is a friend, the nurse is vulnerable to leave the nurse-patient therapeutic role. The beliefs/values and sense of self developed by the nurse are strong determinants for the nurse to engage in a nontherapeutic role.

The third condition, Educating Nurses, moved the focus from the individual nurse to the institutions for learning. The institutions for learning failed to screen adequately for dedicated and emotionally stable candidates for nursing programs. Screens of the past looked for people who wanted to be a nurse and had emotional stability. Additionally, the educational process was faulted for not teaching nurse-patient therapeutic relationships, including boundary crossings, as an ongoing part of the curriculum. Nurses need to have more curriculum content on professional standards and codes of conduct, geared toward maintaining a therapeutic nurse-patient relationship. Both of these areas contribute to the nurse being vulnerable to engage in a nontherapeutic role.

Creating Negative Work Environment, the fourth condition in *Being Vulnerable* of Stage One, primarily focused on the employing agencies creating a negative work environment. The agencies were cited for lacking adequate screens to employ healthy, stable and committed professional nurses. Nurses need to feel free to assess and determine when they are unfit to work and call in for sick leave without being threatened. Additionally, having poorly defined policies on role expectations of nurses with the patients, as well as not having sufficient vehicles for nurses to communicate safely on the topic of nurse-patient relationships, were two other conditions contributing to a negative

work environment and nurses *Being Vulnerable*. Nurses need to have counseling services available as this increases the susceptibility of the nurse to engage in a nontherapeutic role. Salaries were addressed as a negative work environment factor that could lead to a nurse being vulnerable if the nurse has financial problems. Lastly, the negative work environment was a factor for the nurse being vulnerable when orientation and preceptor programs are compromised and the nurse does not receive the needed training and orientation for the work role.

The fifth condition, Lacking Advancement of the Profession, was addressed to the profession as having accountability of the nurse *Being Vulnerable* in two areas. The first was the lack of a definition of a professional nurse and was a significant factor. A nurse is a nurse regardless of educational preparation. Professional nurses and the profession are blamed for actions of staff called "nurses". Another focus cited was poor salaries of the nurse. The concept of the nurse *Being Vulnerable* as a result of a poor salary was that some nurses would be more susceptible to take money or gifts from the patient. Poor salaries were identified as adversely affecting the salience of the professional nurse role. In other words, higher salaries are paid to the more prestigious professionals.

Stage Two, *Straying From the Role*, eight conditions were identified and were referenced to the five conditions of Stage One. In Stage Two, the progression of the N*urse Breaching the Nurse-Patient Therapeutic Relationship* was realized. Nurses engaged in nontherapeutic roles with patients. The first condition, Choosing Nursing, demonstrated that nurses who care have the propensity to get in over their heads with

patients. Also, nurses who were from abusive or dysfunctional families engaged in nontherapeutic roles with patient. The process was evidenced by a distraught nurse who was in a abusive relationship, reversed roles by becoming the patient, being counseled, advised and emotionally supported by the patient. Several other nurses engaged in romantic, financial and sexual relationships with patients or members of the patient's family. The process of the nurse *Straying From the Role*, was attributed to those caring individuals who were attracted to nursing as well as those nurses from dysfunctional families. Additionally, the deficiencies of the beliefs/values and sense of self were part of the process that led nurses to engage in a nontherapeutic role. The focus moved from the nurse to the educational programs, employing agencies (negative work environment) and lastly, the profession of nursing as conditions that facilitate the process of the nurse *Straying from the Role*.

The last stage, Stage Three, *Facing the Consequences*, is the necessary outcome for the nurse to complete the process. There are consequences to each of the conditions when the nurse engages in a nontherapeutic relationship with the patient. The consequences were presented from being rewarded on to facing mild consequences, progressing on to receiving moderate and severe consequences to be faced by the nurse, the patient and the profession.

Interpretation of the Study Results

This grounded theory *Breaching the Nurse-Patient Therapeutic Relationship* discovered that a three stage process is involved for a nurse to engage in a nontherapeutic

relationship with a patient. There are conditions in each stage that contribute to progression of the process. Although the nontherapeutic relationships were on a continuum from under-involvement to over-involvement of the nurse with the patient, most of the emphasis of these participants was on over-involvement of the nurse with the patient. The data primarily supported that over-involvement by the nurse was nontherapeutic. Seemingly, in the over-involvement situations, the outcomes were more obvious, more frequently reported and more damaging to the patient, the nurse and the profession. However, both under and over involvement of the nurse with the patient in nontherapeutic relationships was an expressed concern of some but not all participants.

The beginning theory, *Breaching the Nurse-Patient Therapeutic Relationship*, has merit for acknowledging that there are conditions and contributing factors for the nurse to engage in a nontherapeutic relationship with the patient. As part of the process, *Breaching the Nurse-Patient Therapeutic Relationship*, the nurse has five conditions that can make the nurse vulnerable. Once the nurse is vulnerable, the second stage of the process is set for the nurse to stray from the therapeutic role to a nontherapeutic role. Eight conditions in this stage facilitate the process of the nurse engaging in nontherapeutic activities. Once the nurse has strayed from the role, the last stage, facing consequences, ends the process with consequences that range from receiving rewards to facing severe consequences. This concludes the three stage process of the nurse *Breaching the Nurse-Patient Therapeutic Relationship.*

Integration with the Literature

The review of literature at the onset of the grounded theory study was useful to discern the breadth of the problem for all disciplines and allowed this investigator to narrow the focus to nursing. The review of literature was conducted several years prior to the data collection and analysis. The literature review was conducted under the following categories and will be presented in the same order to note concurrence or dissimilarities.

The practice issue of power in the nurse-patient relationship was a helpful concept as it delineated how the nurse was responsible for any abuse of power. Similar to the self-disclosure literature (Epstein and Simon; 1990; Gutheil and Gabbard, 1993; Reisman, 1986; Rothman, 1989), self-disclosure of personal information by the nurse was found as contributing to a minor infraction initially but lead to an increasing crescendo pattern of more severe nontherapeutic actions (eg. sex). There was a plethora of literature on sex with patients from other disciplines (Gabbard, 1989; Gartrell, et al., 1986; Guthiel and Gabbard, 1993; Holroyd and Brodsky, 1977; Kardner, Fuller and Mensh, 1973; Kluft, 1989; Laury, 1992; Pope, 1989; Vinson, 1984), but only a sparse number of articles for the discipline of nursing (Gallop,1993; Munsat and Riordan, 1990; Smith, Taylor, Keys and Gornto, 1997). These data support that despite the predominance of females to males in nursing, and despite the lack of nursing literature on sex with patients, there is a substantial problem of male and female nurses having sexual relationships with patients. The practice issues of power, self-disclosure, gifts/rewards and sex were all relevant issues in the literature review and were supported by data in this study.

The importance of values/beliefs and ethics found in this theory as contributing to *Breaching the Nurse-Patient Therapeutic Relationship* was consistent with previous literature (Bandman and Bandman, 1994; Benner and Wrubel, 1989); ethical issues were an important part of the theory to explain how the nurse acted was based on his/her belief/value system when engaging in nurse-patient relationships. The importance of the nurse's beliefs/values and ethics was found in this theory to be a major contributing factor for *Breaching the Nurse-Patient Therapeutic Relationship*. There was a clear consensus by participants about the importance of integrating ethical education in nursing programs.

The educational issues addressed in the literature review focused primarily on educating the nurse in the phases of a therapeutic relationship, while some articles addressed boundary crossings in the nurse-patient relationship (Pennington, et al., 1993; Sabey and Gafner, 1996; Smith, Taylor, Keys and Gornto, 1997). The underlying theme found in the literature was that both academic and professional education of nurses help in preventing the nurse from engaging in nontherapeutic roles with patients. It was useful to note in the literature review that regardless of how much education is provided to staff, there are some calculating predatory staff who will deliberately exploit the nurse-patient therapeutic role. These data supported that view point. A notable dissimilarity to the literature was the role of academic institutions as to where the emphasis should be in education. For example, educational programs (institutions) were addressed to have more accountability for screening nurses, integrating subject content to include ethics as well as addressing nontherapeutic roles with patients. The historical spirituality theme of nursing

was congruent with the literature review; however , it was not so much under ethics as under educational screens and educational program content.

The legal issues reviewed in the literature (Coleman and Schaefer, 1986; Jorgenson, Randles and Strasburger, 1991; Sherman, 1993) provided insightful material for the nurse as an individual to be held accountable through nurse practice acts, codes of ethics, and enforced through State Boards of Nursing, as well as state and federal laws. However, the study participants identified the language used by the agencies of nursing to write codes and standards to be confusing. From a legal perspective, the gray ambiguous language made it difficult for administrative staff to enforce compliance to codes and standards. The study data supported the literature in that professional nurses should be held accountable to the State Boards of Nursing for deviations from the professional role.

Summary

This section summarized the interpretation of the study results and the integration with the literature. The original literature review included practice issues, ethical issues, educational issues and legal issues related to the nurse-patient relationship. The subsequent literature review encompassed the recent studies on nurse-patient relationships. For this study, the core category, *Breaching the Nurse-Patient Therapeutic Relationship*, conceptualized a process for the nurse to engage in a nontherapeutic relationship with the patient. A three stage process with five conditions was identified as contributing to the nurse *Breaching the Nurse-Patient Therapeutic Relationship*. The findings of this study support the beginning theory that there is a process for the nurse to

breach the therapeutic nurse-patient relationship under the identified conditions of each stage.

Congruence with Theoretical Framework

The theoretical perspective of symbolic interactionism undergirded this grounded theory study (Blumer, 1969; Crotty, 1988; La Rossa and Reitzes, 1993), along with elements from identity theory and ethics. It was not surprising therefore, that research findings were congruent with the theoretical perspectives. The research also demonstrated the appropriateness of using symbolic interactionism as the theoretical perspective with the integrated elements of identity theory and ethics. This section highlights some of the key linkages between study findings and the symbolic interactionism, identity and ethical theoretical frames of reference.

The symbolic interactionist perspective has three tenets, that a) human beings act toward things based on the meanings that things have for them; b) these meanings are derived from social interactions; and c) meanings are modified through an interpretive process used by the person in dealing with things encountered (Blumer, 1969).

This study revealed that nurses acted toward patients based on the meanings that patients had for them. For one nurse, the patient became the nurse's support agent. Several other nurses engaged in social, romantic and sexual relationships with the patients. These meanings that the nurses came to have about the patients were derived from social interactions. However, the meanings were modified by the nurses through an interpretive process to meet the nurses own unfulfilled needs.

The development of self-concept is through a process of social interaction (Blumer, 1969). The concept of self, once it is developed, serves as an important motive for behavior (La Rossa and Reitzes, 1993). The last concept in the development of the self-concept is that individuals and small groups are influenced by larger cultural and societal processes (La Rossa and Reitzes, 1993).

The self-identity of the nurses who engaged in nontherapeutic roles with patients was blurred in their identity of being a professional nurse. The strong emphasis by study participants that the nurses need to be socialized into nursing and to embrace the values of the profession captured this self-identity theoretical component.

In Styker's (1980) identity theory, the identity aspect refers to the self-meanings in a role. This self-identity is congruent with Blumer's (1969) symbolic interactionism identity of human beings acting toward things based on the meanings that the things have for them. The behavior of a person was understood and conceptualized from the influence of the person's beliefs, values, ethics and attitudes (Stokes and Hewitt, 1976).

The nurse adequately socialized into the professional nurse's role would give credible salience to the professional role, would have the beliefs/values/ethics to place emphasis on the patient's needs being paramount in every nurse-patient encounter. This socialization process would influence the nurse's behavior to remain in the therapeutic zone of helpfulness with the patient. Participants strongly agreed with this socialization process to facilitate professional self-identity of the individual nurse.

The last element of theoretical framework, ethical concepts, was examined from

the context of how ethics influence human behavior (Bandman and Bandman, 1994; Silva, 1990). Caring, serving as a patient advocate, practicing morality are part of the ethical philosophy (Bandman and Bandman, 1990; Benner and Wrubel, 1989; Curtin, 1979; Sarvimäki, 1988; Silva, 1983; 1990). The literature review of this ethical theoretical element provided the investigator a heuristic question to pose to participants: Where and how did you develop your beliefs/ values about the nurse-patient relationship? The topic surfaced early on with the Focus Group participants but took an unexpected turn to reflect on how the profession of nursing has moved away from it's spiritual origins. The concluding statements were strong indicators that nursing, as a profession, needs to return to its roots in the areas of advocating for ethical, moral and competent people to enter nursing education programs. These study data support the ethical theoretical framework.

Implications for Nursing Theory

The potential of the grounded theory, *Breaching the Nurse-Patient Therapeutic Relationship,* may serve to enhance the nursing profession's perspective on defining, supporting and advancing the core element of nursing: the nurse-patient therapeutic relationship. Grounded theory, as a research methodology, has promise for providing new insights into the complex phenomena of the nurse-patient relationship. This method provides an opportunity to focus on concerns of nursing staff that may have been ignored in the past. Some concerns were the significant influence of educational programs, employing institutions and professional organizations that participate in the development

and outcome of the nursing profession. The discovery of philosophical and ethical beliefs of each could be used toward developing a more formal interactive theory for nursing. The practice of nursing is interactive and dependent with education programs, employing agencies and professional organizations. It is important to discover what accountability role each has when a nurse does engage in a nontherapeutic relationship with a patient and use the information toward developing a theory.

Another implication of this study for nursing theory is one to build on the works of Peplau (1952, 1969; Beeber, Anderson and Sills, 1990; Forchuk 1992; Forchuk and Brown 1989; Lego 1980). In addition to defining the phases of the therapeutic nurse-patient relationship, expand the complex human nurse-patient relationship phenomena to incorporate ethical, therapeutic and legal consequences when the nurse engages in a nontherapeutic relationship with the patient. The incentive for nurse theorists to devise effective ways of representing this phenomena in a cause-effect process with realistic consequences to nurses who might violate the therapeutic components of the nurse-patient relationship may offer benefits to society and the profession. It would be helpful to have such a theory without ambiguities or contradictions which can interfere with the process of dealing with nurses in violation. This study may be helpful as a tool for clinical intervention. The three stage process could be used as an outline for clinical discussion to address actual clinical situations of challenging nurse-patient relationships.

In summary, the benefit of having a more formal theory on nurse-patient relationships that incorporates philosophical and ethical beliefs of the influencing

agencies, education, employment and profession, and a theory which emphasizes outcomes of a consequential nature may be beneficial to the profession as well as society.

Implications for Nursing Research

This study serves as an example of the value of using the qualitative method, grounded theory, to enhance the development of nursing knowledge as applied to theory construction in nursing. The method permitted the researcher to enter territories that were of concern to experienced nurses. More on the philosophical and theoretical perspective of nurses who have been investigated by the State Board of Nursing would provide beneficial information to enhance this beginning theory. These nurses have experienced serious charges and faced consequences. Their experiences would provide valuable knowledge and maybe suggest preventive interventions for others to use.

Another implication of this study is the need for collaborative interactions with the institutions of learning, agencies of hiring, as well as the professional nursing organizations. The nursing profession writes standards, the education and employing agencies have practice guideline standards. However, the individual nurse is often guided by his/her own beliefs/values/standards in the practice arena. Therefore, some integrative/collaborative research to collect data that could help to understand and direct the action of nurses at the grass-roots level would be beneficial. For example, write the professional and educational standards from clinical practice experts; use the language of the clinicians since the participants in this study identified the language of the standards to be ambiguous, confusing and not helpful. The individual nurse at the grass-roots level

would have clear guidelines of professional and therapeutic nurse-patient relationships; the initial, working, and termination phases would be clearly defined, along with positive and negative consequences. The benefits would be for the patient, the nurse, the profession of nursing and for society. The paucity of research in this area of nurse-patient relationships has implications for other qualitative methods of inquiry, as well as quantitative methods. Research that contributes to nursing's base of knowledge in the nurse-patient relationship has merit for making a substantial advancement in nursing. The advancement may be to develop middle range theories directed at maintaining the relationship within the zone of helpfulness but with clear legal consequences when deviations occur.

This study involved nurses with years of nursing experience who were older nurses. The experienced nurses identified a philosophical and ethical difference in them versus the nurses graduating today. From this context, another implication for future research would be to discern if there is a philosophical and ethical difference based on age and years of experience in nursing. Additionally, some comparative studies of various educational programs to determine what screens are used for admission to the program, as well as to see if any attempt is made to determine a nursing candidate's fitness for nursing. It would be helpful to have empirically based admission criteria which might offer some support of this emerging theory of the nurse who is unfit for nursing and is vulnerable in the process of *Breaching the Nurse-Patient Therapeutic Relationship*. Additionally, more research is indicated in the hiring practices to

determine which nurses are vulnerable for engaging in a nontherapeutic nurse patient relationships.

One assessment tool, in the developmental stages, is the Pennington Professional Boundaries Scale (Pennington, 1993). This instrument is being developed for the individual nurse's self-assessment and has implications for educational purposes as well. The tool will be used for assessing the appropriateness of specific behaviors by the nurse in the nurse-patient relationship. It is devised as an assessment tool to promote growth and understanding of the parameters of the nurse-patient relationship.

Implications for nursing research were summarized in this section. Future studies using the qualitative method was suggested to discover more on the philosophical and theoretical perspective of nursing staff who have been investigated by the State Board of Nursing. Other interactive/collaborative research with institutions of learning and hiring, as well as the profession of nursing, to determine what role each has in nursing actions at the nurse-patient relationship level and to develop some clear standards and guidelines for use in the clinical area. Other studies would include some comparative studies to discern philosophical and ethical differences of new graduates and experienced nurses. Additionally, some comparative studies to determine differences in screening for admission to schools of nursing and hiring of employment. This would be helpful if it could determine criteria for fitness to nursing.

Implications for Nursing Practice

The practice of nursing is based on nurse-patient relationships. The threat of a

nurse engaging in nontherapeutic relationships with a patient can cause harm to the patient, the nurse, the employing agency, the profession and to society. The grounded theory *Breaching the Nurse-Patient Therapeutic Relationship* provides a beginning knowledge base to offer clinical intervention and guidance. The theory enables individual nurses, supervisory nurses, educator nurses and investigator nurses to have a theoretical frame of reference to influence clinical actions. The theory offers an opportunity for all staff involved in a situation with a nurse engaging in a nontherapeutic relationship with a patient to examine the three-stage process, examine the five conditions inherent in the three stages and reflect back to the case at hand. What can be drawn from the theory to assist in the management of the case? Hopefully, the theory will provide a framework for assessing and intervening for outcomes before a crisis evolves.

Nurses may use the theory in clinical practice through educational interventions. This may include educational programs, staff counselings or peer review. Nurses who are involved in nontherapeutic relationships with patient may be assisted to examine the complexity of the related behaviors. Preventive educational programs could incorporate the theory with strategies to remain in a therapeutic relationship with patients. This theory clearly explicates that there are consequences to face when the nurse engages in a nontherapeutic relationship with the patient. This should be made clear with no ambiguities or exceptions. Nurses need more education on the State Board of Nursing and the consequential actions that may occur when a nurse steps out of the therapeutic nurse-patient role. This theory provides such an educational/clinical practice perspective.

In summary, this section summarized the implications of this grounded theory for nursing practice. The theory offers a theoretical frame of reference to help guide education and practice of nurses in their nurse-patient therapeutic relationships.

Recommendations

This study is viewed as an initial step in addressing the process of a nurse engaging in a nontherapeutic relationship with a patient. It is expected that the theory will be modified over time and with experiences gained in testing it. Conducting this study has resulted in the identification of the following questions for further study:

1. What are the philosophical and ethical differences between new graduates and experienced nurses? What are the differences in their definition of a therapeutic nurse-patient relationship?
2. What early interventions did a nurse have from the educational program and the employing agency before engaging in a nontherapeutic relationship with a patient and before being investigated by the State Board of Nursing?
3. What knowledge does the nurse have about legal actions that may be taken for breaching the nurse-patient therapeutic relationship?
4. What understanding does the nurse have on policies/standards of conduct on the nurse-patient relationship?

Summary of Chapter Five

In this chapter, study finding were presented and integrated with extant literature review. The core category of the study, *Breaching the Nurse-Patient Therapeutic*

Relationship, was reviewed in three stages with five identified conditions. The theory was conceptualized in the nurse being susceptible to engage in a nontherapeutic relationship with the patient in the three stage process and with specified conditions of each stage. The review of literature was helpful under the categories of practice, ethical, educational and legal issues. The study findings were dissimilar from the literature review in the following areas: The practice issues showed that this study had substantial problems with male and female staff having sexual relations with patients. Educational issues digressed to hold educational programs accountable for screening for more qualified ethical candidates for nursing schools. Implications for nursing theory, nursing research and nursing practice concluded this chapter.

APPENDIX A: INITIAL INTERVIEW SCREEENING

Initial Interview Screen

1. First Name
2. Educational Degree in Nursing
3. Field of Nursing
4. Years of Nursing Experience
5. Description of Boundary Moving/Violation

    Personal

    Co-Worker

    Supervisor

    Year of Event

    Significant of event: Addressed by:

        State Board of Nursing _____

        Management Staff at Employing Facility _____

6. Able to recall a) the specifics of the event b) details of the nurse's behavior leading to the event c) outcome of the event.

APPENDIX B: QUESTION GUIDELINE FOR INDIVIDUAL AND FOCUS GROUP INTERVIEWS

Question Guideline for Individual and Focus Group Interviews

1. Describe the events of processes that lead the nurse to engage in a nontherapeutic relationship with the patient.

2. What, if any, is the special bond that makes the nurse-patient relationship therapeutic?

3. When does the nurse cease toe be therapeutic?

4. How much helpfulness/caring by the nurse is therapeutic?

5. How much helpfulness/caring by the nurse is too much/not enough?

6. How can a nurse be close and distant in a therapeutic relationship?

7. Where and how did you develop your beliefs/values about the nurse-patient relationship?

8. In your opinion, what circumstances lead to the nurse leaving the therapeutic zone of helpfulness with the patient and becoming over/under involved with the patient?

9. In your opinion, what would help nurses stay in the therapeutic zone of helpfulness?

10. What else do I need to know about this issue of the nurse-patient therapeutic relationships?

APPENDIX C: HUMAN SUBJECTS APPROVAL

THE UNIVERSITY OF
ARIZONA®
HEALTH SCIENCES CENTER

Human Subjects Committee
13 February 2001

1622 E. Mabel Street
P.O. Box 245137
Tucson, AZ 85724-5137
(520) 626-6721

M. Sue Pennington, Ph.D. Candidate
Advisor: Terry Badger, Ph.D.
College of Nursing
PO BOX 210203

RE: **HSC A01.20** NURSE-PATIENT THERAPEUTIC RELATIONSHIPS: A GROUNDED THEORY STUDY

Dear Ms. Pennington:

We received your revised consent form for the above-cited research study. The procedures to be followed in this study pose no more than minimal risk to participating subjects. Regulations issued by the U.S. Department of Health and Human Services [45 CFR Part 46.110(b)] authorize approval of this type project through the expedited review procedures, with the condition(s) that subjects' anonymity be maintained. Although full Committee review is not required, a brief summary of the project procedures is submitted to the Committee for their endorsement and/or comment, if any, after administrative approval is granted. This project is approved effective 13 February 2001 for a period of one year.

The Human Subjects Committee (Institutional Review Board) of the University of Arizona has a current assurance of compliance, number M-1233, which is on file with the Department of Health and Human Services and covers this activity.

Approval is granted with the understanding that no further changes or additions will be made either to the procedures followed or to the consent form(s) used (copies of which we have on file) without the knowledge and approval of the Human Subjects Committee and your College or Departmental Review Committee. Any research related physical or psychological harm to any subject must also be reported to each committee.

A university policy requires that all signed subject consent forms be kept in a permanent file in an area designated for that purpose by the Department Head or comparable authority. This will assure their accessibility in the event that university officials require the information and the principal investigator is unavailable for some reason.

Sincerely yours,

David G. Johnson, M.D.

David G. Johnson, M.D.
Chairman
Human Subjects Committee

DGJ:rs
cc: Departmental/College Review Committee

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