Nurses' experiences of professional boundaries in mental health care

A multisite qualitative study using source triangulation

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Abstract

Background: Professional boundaries are essential in any professional-patient relationship. Professional boundaries are necessary to establish and maintain therapeutic relationships between patients and the professionals who provide healthcare. Appropriate boundaries provide a safe frame for treatment, while inappropriate boundaries can cause harm to patients and professionals. Professional boundaries are especially important to nurse-patient relationships in mental health care, because patients with mental illnesses can be especially vulnerable and therapeutic use of self is the main therapeutic tool in mental health nursing.

Aim: The main purpose of the study was to explore nurses' perceptions of and experiences with being professional, personal, and private in nurse-patient relationships in mental health care. Five research questions accompanied the main purpose: 1) How do nurses define being professional, personal, and private, 2) How do nurses explain their professional boundaries, 3) What kind of personal information do nurses share with patients, 4) What influences the nurses' decisions to share or withhold personal information, and 5) How do nurses describe their contact with current and/or former patients outside of work hours?

Methods: In this study, I have used a qualitative approach that reflects hermeneutic phenomenology with its emphasis on interpretation and reflexivity. The study was a qualitative multisite study with source triangulation. Sixteen nurses who worked in mental health care participated in the study. Four worked in community mental health services, while 12 worked in specialist mental health services. The nurses partook in participant observation, individual interviews and focus group interviews. The data collection methods were sequential and complemented each other.

Results: The study's results are presented in three papers that addressed specific research questions directly and the study's purpose indirectly. Together, the papers' results demonstrated that the nurses perceived being professional, personal, and private as interconnected. The nurses' personalities and personal preferences played into their decisions regarding professional boundaries related to self-disclosure and dual relationships (Papers 1 and 2). The nurses' experiences pointed to a clinical reality where nurses made boundary decisions on a case-by-case basis because context and particular relationships had vital importance (Papers 1, 2 and 3). Since professional boundaries were contextual and relational, nurses had to rely on their own individual judgements (Paper 3).

Discussion: Based on the study's results, I discuss two issues. First, I question and discuss whether professional boundaries are a personal responsibility. The legal viewpoint in Norway

is that nurses are fully responsible for their boundary decisions. I suggest that it would contribute to safer therapeutic nurse-patient relationships if colleagues and employers joined nurses in ethical deliberations on boundary issues. Secondly, I discuss the power and predicaments of a personal approach. It seems that human-to-human relationships between nurses and patients are important to outcomes in mental health care, which challenges a distant professional role. However, boundary transgressions can have detrimental consequences for patients and nurses, and there are good reasons to use caution.

Conclusion: The study suggests that nurses deal with difficult boundary decisions that can have serious consequences for themselves and their patients. The study supports earlier research from different disciplines that acknowledges diverse reasons for nurse self-disclosure, the many dilemmas of dual relationships and the emphasis on the importance of context in decisions related to professional boundaries. The study is, as far as I know, one of few empirical studies on professional boundaries in mental health nursing.

List of papers

Paper 1

Unhjem, J. V., Vatne, S., & Hem, M. H. (2017). Transforming nurse-patient relationships–A qualitative study of nurse self-disclosure in mental health care. *Journal of clinical nursing*, 27(5-6), e798-e807

Paper 2

Unhjem, J. V., Hem, M. H., & Vatne, S. (2018). Encountering Ambivalence–A Qualitative Study of Mental Health Nurses' Experiences with Dual Relationships. *Issues in mental health nursing*, 39(6), 457-466

Paper 3

Unhjem, J. V., Hem, M. H., & Vatne, S. (Under review). The ethics of being professional and personal - A feminist perspective on boundaries in nurse-patient relationships in mental health care. *Advances in Nursing Science*

1 Introduction

Appropriate professional boundaries are necessary to ensure therapeutic relationships between patients and the professionals who provide healthcare (Stuart, 2013). Well-managed boundaries provide a safe frame for treatment (Gabbard, 2016; Gutheil & Brodsky, 2011), while inappropriate boundaries can have detrimental consequences like re-traumatization for patients (Gutheil & Brodsky, 2011) and the risk of burnout for professionals (Skovholt & Trotter-Mathison, 2016).

Professional boundaries are essential in any professional-patient relationship. However, in this study, my interest lies primarily with nurses. There are three reasons for this: First, I am a nurse and my experience with patient-relationships comes from nursing practice. In my nursing practice, I saw how colleagues and I differed in our professional boundaries. Moreover, I saw how my own boundaries changed as I became more experienced. Secondly, the nurse-patient relationship is the cornerstone of nursing. Thirdly, by keeping the study focused on one profession it is easier to identify and limit relevant literature. In addition, professions vary with regard to practice settings, treatment approaches, and the theoretical frameworks that guide their work.

While professional boundaries are fundamental in every nurse-patient relationship, I believe professional boundaries are especially important to nurse-patient relationships in mental health care. Mainly for two reasons. One reason is that patients who seek help for their mental health problems are vulnerable (Jones, Fitzpatrick, & Rogers, 2016) and some of them are particularly at risk for boundary transgressions due to their mental health issues (Gutheil & Brodsky, 2011, p. 201). The second reason is that nurses' therapeutic use of self, which involves making use of their personal qualities, is the key tool to mental health nursing (Stuart, 2013).

Broad concepts, like professional boundaries, are "relatively abstract and removed from the data" and they may encompass concepts at lower levels (Morse, 2017, p. 98). There are different definitions of professional boundaries, but most of the time the concept *boundaries* is used to describe "the not-to-be-crossed line between proper and improper human contact" between professionals and patients (Skovholt & Trotter-Mathison, 2016, p. 57). Touching and sexual behavior are examples of physical boundaries, while feelings and interests are examples of psychological/emotional boundaries (Jones, 2016). These examples are lower level concepts that are closer to the empirical reality (the data).

In my study, I wanted to explore nurses' perceptions of and experiences with being professional, personal, and private in nurse-patient relationships in mental health care. Being professional, personal, and private are behavioral concepts (concepts that refer to a set of behaviors), and their meaning vary depending on context (Morse, 2017, p. 101). While nursing literature often mentions these concepts in relation to the nurse-patient relationship and professional boundaries, I have yet to find them clearly and consistently defined. I hoped that my study would yield concrete descriptions of the concepts' features based on the nurses' empirical reality.

I developed five research questions to help achieve the study's purpose. The first two research questions addressed professional boundaries in general:

1. How do nurses define being professional, personal and private?
2. How do nurses explain their professional boundaries?

The next three research questions addressed specific boundary issues:

3. What kind of personal information do nurses share with patients?
4. What influences the nurses' decisions to share or withhold personal information?
5. How do nurses describe their contact with current and/or former patients outside of work hours?

The study excludes professional boundaries related to physical touch and non-verbal communication. This exclusion is based on my research interests. I acknowledge that physical touch and especially non-verbal communication (such as facial expressions of emotions) are important parts of the communication in nurse-patient relationship and that they are influenced by cultural practices, individual preferences and professional boundaries (Reamer, 2012). For a discussion of physical touch between mental health professionals and patients, see Gutheil and Brodsky (2011). As my study took place within a society where health services are public and mostly free, I do not give fiduciary aspects any attention. Fiduciary aspects are, however, included in other publications on professional boundaries (Epstein, 1994; Gutheil & Brodsky, 2011; Reamer, 2012).

A note on language: I use the term *professionals* when I refer to health professionals in general or when the text refers to more than one type of health professional. The term *nurse* is used when referring to nurses specifically. *Mental health nursing* covers in this thesis nursing practice by both general nurses and specialized mental health nurses. I use the term *patient* throughout the thesis, but the literature I cite may have used other terms, such as client or service user. I use *mental health care* synonymously with mental health care services and

psychiatric services. I do not differentiate between mental health nursing and psychiatric nursing.

Table 1 presents an overview the study.

TABLE 1 OVERVIEW OF THE STUDY

STUDY PURPOSE	To explore nurses' perceptions of and experiences with being professional, personal and private in nurse-patient relationships in mental health care		
	Paper 1	Paper 2	Paper 3
TITLE	Transforming nurse-patient relationships–A qualitative study of nurse self-disclosure in mental health care	Encountering Ambivalence–A Qualitative Study of Mental Health Nurses' Experiences with Dual Relationships	The ethics of being professional and personal – A feminist perspective on boundaries in nurse-patient relationships in mental health care
AIM	To describe what nurses self-disclose to patients in mental health care and what reasons they have for self-disclosure	To explore how nurses describe their contact with current and/or former patients outside work hours	To explore nurses' descriptions of being professional, personal and private, and how these terms relate to one another
RESEARCH QUESTION	Addresses research questions 3 and 4	Addresses research question 5	Addresses research questions 1 and 2
DESIGN	Multi-site study with purposive sampling and source triangulation	Multi-site study with purposive sampling and source triangulation	Multi-site study with purposive sampling and source triangulation
SAMPLE	16 nurses working in mental health care	6 mental health nurses	16 nurses working in mental health care
DATA	Participant observation Individual interviews Focus group interviews	Individual interviews Focus group interviews	Participant observation Individual interviews Focus group interviews
ANALYSIS	Systematic text condensation	Thematic analysis	Systematic text condensation

2 Background

Mental health nursing is the context within which professional boundaries exist, so in this chapter, I begin with reviewing literature relevant to mental health nursing before presenting literature on professional boundaries. I briefly describe some main characteristics of mental health nursing that textbooks on the subject emphasize. Then I look more closely at the role of the nurse-patient relationship and use of self. As I will show, the nurse-patient relationship is essential to nursing practice and nurses' therapeutic use of self is crucial to the development of therapeutic relationships with patients. I have chosen to include sections about models of care in mental health services and common factor models. Models of care influence nursing settings through policies and priorities. Common factor models suggest that certain factors (like the therapeutic relationship) that do not depend on specific treatment approaches account for much of patients' recovery from mental illnesses.

Furthermore, I detail the issue of professional boundaries by giving an overview of boundary theory, including boundary transgressions, before I pay special attention to legal role boundaries and professional codes of ethics. I will present an overview of some selected boundary issues and give attention to literature reporting empirical research on professional boundaries in nursing. Laws and ethical codes of conduct regulate nurse practice, and I consider how the Norwegian Health Act and the Norwegian Nurses' Organization's ethical guidelines address professional boundaries. A brief description of care ethics concludes the background chapter. Care ethics provides a perspective that I think is very promising for understanding the interplay between being professional, personal, and private. I hope that the background chapter provides a useful frame of reference for those who are new to the topics as well as those who are familiar with it.

2.1 Mental health nursing

Mental health nursing as a discipline stems back to the 1880's when a school to prepare nurses to care for the mentally ill was opened in the USA (Stuart, 2013). It was advanced further by Hildegard E. Peplau's book *Interpersonal Relations in Nursing* (1952), the first to describe a theoretic framework for mental health nursing. Peplau's interpersonal relations theory has influenced (and still does) the relations perspective in mental health nursing (D'Antonio, Beeber, Sills, & Naegle, 2014; Hummelvoll, 2012). The relations perspective, together with traditions for milieu therapy and community based mental health nursing, continue to be important in Norwegian mental health nursing (Hummelvoll, 2012).

Mental health nursing is a nursing specialty defined as a planned, caring and psychotherapeutic practice (Hummelvoll, 2012, p. 43). It involves contributing to solving the

patients' health problems through cooperation with the patient. The nurse is a caregiver and spokesperson for patients in need. Mental health nursing is "an interpersonal process that promotes and maintains patient behavior that contributes to integrated functioning" (Stuart, 2013, p. 6). Nursing interventions include psychological first aid, milieu therapy and psychosocial interventions (Buus, 2009).

Mental health nursing take place within services that have gradually become more decentralized, relationship oriented and focused on user involvement (Bøe & Thomassen, 2017). Practice settings include, but are not limited to; psychiatric facilities, community mental health centers, psychiatric units, and community-based treatments (Stuart, 2013). In Norway, in-patient care is provided by specialist mental health care in hospital units and district psychiatric centers (DPS), while outpatient care includes DPS's and community mental health care (Snoek & Engedal, 2008, 2017). Most psychiatric institutions have in-patient units and out-patient clinics (Juklestad & Aarre, 2018, p. 65). Both specialist and community mental health care provide ambulatory mental health services like assertive community teams. Ambulatory services are a relatively new service and availability and waiting time vary (Juklestad & Aarre, 2018). Nurses who specialize in mental health care work in these different practice settings together with nurses without specialization and other professionals (Buus, 2009).

In Norway, during the course of 12 months, 16 – 22 percent of the adult population will experience mental illness and the most common mental illnesses are anxiety disorders, depression and drug addiction (Folkehelseinstituttet, 2014, 2018). Anxiety disorders include phobias and generalized anxiety. Depressions include mild, moderate or severe depressions (Folkehelseinstituttet, 2018). Although mental illnesses are widespread in the population, only a minority seek help from public mental health care services (Folkehelseinstituttet, 2018, p. 33). Among those who do seek help, many struggle with depression and anxiety disorders, and the majority are women (Folkehelseinstituttet, 2018).

In sum, this means that nurses working in mental health care provide different nursing interventions to patients with different mental health issues in several different nursing settings. Despite the diversity in patient groups, nursing interventions and settings, some aspects are universally important to mental health nursing – the first of which is the nurse-patient relationship.

2.1.1 The nurse-patient relationship

The relationship between the nurse and the patient is essential to nursing in general and to mental health nursing specifically (Kristoffersen, Skaug, & Nortvedt, 2011; Peplau, 1952; Stuart,

2013; Travelbee, 1971; Welch, 2005). Nurse-patient relationships are at the heart of mental health nursing because they "form the basis of nursing interventions for psychiatric-mental health nursing" (Jones et al., 2016, p. 18). The establishment of a therapeutic relationship is the primary role of nurses in mental health care (Gallop, 1998b). The relationship is goal oriented and aims at promoting the patient's growth and well-being (Stuart, 2013) through assisting the patient with preventing, coping with or finding meaning in experiences of illness and suffering (Travelbee, 1971). The relationship between a nurse and a patient is asymmetrical and one-sided given the patient's need for help and the nurse's duty to provide care (Kristoffersen et al., 2011), but it is also considered a mutual learning experience (Stuart, 2013). Whether the relationship is successful in reaching its goals depends on the quality of the relationship. Different theorists and researchers have identified diverse qualities that they state are crucial. Peplau's *Interpersonal Relations Theory* promotes presence, congruency, openness and self-disclosure as some of the essential qualities of a therapeutic relationship (Stockmann, 2005).

The priority of therapeutic relationships in nursing literature is unsettled by recent findings that this is not the reality in clinical settings (Cutcliffe & McKenna, 2018; Cutcliffe, Santos, Kozel, Taylor, & Lees, 2015). A review of inpatients' evaluations concluded that care experiences were severely lacking warm therapeutic relationships across the United Kingdom, Portugal, Canada, Switzerland, Germany and Australia (Cutcliffe et al., 2015). Inpatients' experiences were, however, characterized by "coercion, disinterest, inhumane practices, custodial and controlling practitioners and a gross over use of pharmacological 'treatments'" (Cutcliffe et al., 2015, pp. 381-382). Patients with mental health issues have shared their experiences with feeling unable to be themselves in professional relationships, being treated like an object to be fixed, paternalistic interactions and relentless frustration over being misunderstood (Gaillard, Shattell, & Thomas, 2009; Ljungberg, Denhov, & Topor, 2016). An older study, that described how patients perceived their interactions with psychiatric nurses, found that although nurses were friendly and caring, interactions were characterized by stereotyping, custodialism, rule enforcement, lack of intimacy, lack of empathy and denial (Müller & Poggenpoel, 1996). In addition, Welch (2005) claims that the therapeutic relationship is notoriously undefined. Concepts that are associated with the therapeutic relationship, like empathy and self-disclosure, also require further clarification (Welch, 2005). The associated concepts have tended to be developed for use in psychotherapy and "do not directly or specifically describe a nursing relationship," claims Welch (2005, p. 161). Despite the difficulties with delineating therapeutic relationships, the relationships' importance seems ascertained.

The amount of publications probing relationships between professionals and patients suggests that relationships are paramount in providing care across different disciplines. Some recently published books in Norway spotlight alliance in cognitive behavioral therapy (Kåver & Gröhn, 2012), good relationships in social work (Aamodt, 2014) and helpful relationships in psychology (Wormnes, 2013). According to patients, the quality of their relationship with the professional decides its helpfulness (Denhov & Topor, 2012; Topor & Ljungberg, 2016). Both patients (Borg & Kristiansen, 2004; Cutcliffe et al., 2015) and professionals (Ness, Borg, Semb, & Karlsson, 2014) in mental health care emphasize the importance of human relationships where they are seen as individual human beings – not just as professionals or patients.

I have noticed that some of the recent literature on relationships echo Carl Rogers' thoughts about necessary and sufficient conditions for personal growth by giving weight to the health professionals' attitudes and feelings about the patient and the relationship and vice versa (Aamodt, 2014; Skau, 2011; Wormnes, 2013). Rogers stipulated six conditions for therapeutic personality change (Rogers, 1957). One of the conditions is commonly referred to as genuineness, congruence or transparency (Wyatt, 2001). Genuineness is essential to a quality therapeutic relationship in mental health nursing, according to a review of research literature (Dziopa & Ahern, 2009). Rogers might not have received the deserved recognition from all "the authors who have since advocated for a deeper appreciation of the "real" therapist-client relationship" (Gibson, 2012, p. 292), but at least some nursing textbooks acknowledge Rogers' contribution. One textbook in mental health nursing describes Rogers' conditions as a psychosocial intervention fundamental to establishing and maintaining therapeutic relationships (Buus, 2009). Another textbook in mental health nursing refers to Rogers when detailing nurse's empathic understanding (although Rogers is strangely not mentioned in the sections about genuineness and respect – the latter being described as synonymous with unconditional positive regard) (Stuart, 2013). To me, it seems clear that Rogers' ideas about what constitutes therapeutic relationships have been and still are quite influential across various health disciplines.

It lies outside the scope of this thesis to provide an overview of the literature on nurse-patient relationships or therapeutic relationships in general, but I wanted to present a brief description of some central characteristics and influential ideas that are relevant to understanding the significance of relationships in mental health nursing.

2.1.2 Therapeutic use of self

The personal qualities of the nurse influence the nurse-patient relationship through nurses' therapeutic use of self. Therapeutic use of self is distinct from the professional's *person* in

therapeutic relationships (Wosket, 2017). It involves "the operationalization of personal characteristics so that they impact on the client in such a way as to become potentially significant determinants of the therapeutic process" (Wosket, 2017, pp. 11-12). A nurse's ability to use the self therapeutically has been recognized as a characteristic of professional nursing for decades. Travelbee saw that therapeutic use of self in combination with a disciplined intellectual approach was necessary to meet the needs of patients (Travelbee, 1971). A nurse uses herself therapeutically when she "makes use of her personality and knowledge in order to effect a change in the ill person" (Travelbee, 1971, p. 19). Therapeutic use of self embraces a range of abilities. It requires, according to Travelbee, "self insight, self understanding, an understanding of the dynamics of human behavior, ability to interpret one's own behavior as well as the behavior of others, and the ability to intervene effectively in nursing situations" (Travelbee, 1971, p. 19).

Therapeutic use of self has been described as a process "by which the knowledge and skills of nursing are employed in a uniquely personal way by each individual nurse" (Uys, 1980, p. 180). A current psychiatric nursing text book states that "the key therapeutic tool of the psychiatric nurse is the use of oneself" (Stuart, 2013). The text book continues with listing and describing personal qualities: self-awareness, clarification of values, exploration of feelings, role modeling, altruism, and ethics and responsibility (Stuart, 2013). A review of nurse-patient interaction in acute adult inpatient mental health units found that patients valued certain personal qualities in nurses, like having a sense of humor and non-judgementalism (Cleary, Hunt, Horsfall, & Deacon, 2012). Together with clinical skills, therapeutic use of self is the foundation of a therapeutic nurse-patient relationship in mental health care.

2.1.3 Models of care in mental health

Psychodynamic approaches have a strong tradition in Norwegian psychiatry (Malt, 2018) and have played an important part in psychiatric practice far into the 1990's (Kringlen, 2007), although diagnostic and biological models received more attention internationally from the 1980's (Kringlen, 2007). "The field of mental health care is one of competing paradigms and understandings about what constitutes mental health and illness", states one study into models of care delivery in mental health nursing practice (Carlyle, Crowe, & Deering, 2012, p. 222). Ramsdal (2013) claims that specialist mental health care and community mental health care move in different directions: the former moving toward a strengthened biomedical perspective, while the latter toward a sociological perspective that puts emphasis on users experience and empowerment. Aarre (2018a), on the other hand, describes how mental health care services are under pressure from these contradicting perspectives – leaving service

providers to manage caregiving under irreconcilable conditions. One study about assertive community treatment reports that New Public Management has led to registering interventions as opposed to considering whether the interventions lead to a better quality of life for the patients (Meese & Ekeland, 2017). The medical model has dominated mental health nursing despite the emphasis on interpersonal relations in nursing literature (Carlyle et al., 2012), but ideas about the nurse-patient relationship as the center of nursing practice find "renewed relevance within nursing and health-care as concepts such as 'patient centered care', 'partnering with patients' and 'strengthening the autonomy of patients and families' are emphasized in healthcare reform standards" (D'Antonio et al., 2014, p. 312).

Recovery as a concept and field of knowledge and research has gradually developed within mental health and drug addiction care in Norway the last 20 years (Karlsson & Borg, 2017). It is a humanistic perspective that gives attention to life stories, personal meanings, growth and development, as opposed to the traditional perspective that focuses on illness history, pathology, diagnostics and treatment (Aarre, 2018a). Regardless of increased application, the recovery concept is inconsistently defined (Le Boutillier et al., 2011) and leaves "a need for conceptual clarity" (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011, p. 445). Very different and divergent practices within mental health care are referred to as recovery oriented, concludes a rapport from 2013 (Borg, Karlsson, & Stenhammer, 2013). The Norwegian Ministry of Health states that the recovery perspective acknowledges the service user as an expert and that the relationship between service providers and service users should be characterized by equality, openness, honesty, and trust (Borg & Topor, 2007; Helsedirektoratet, 2014). Service providers support service users so that they can manage their lives on their own as much as possible (Borg & Topor, 2007).

Recovery from mental illness can be a complex and time-consuming process that involves deeply personal changes (Anthony, 1993). A "seemingly universal" aspect of the recovery concept is the notion that "recovery is a deeply human experience, facilitated by the deeply human response of others" (Anthony, 1993, p. 18). All the while the individual experience is essential to the recovery process, it is important to avoid making it a professionally defined method (Schön & Rosenberg, 2013). "To support personal recovery, mental health systems will need to shift away from a dominance of institutional responses, drug treatments and coercive interventions," assert Slade et al. (2014, p. 13). Service providers take the role of change agents, lobbyists, and breakers of barriers in a recovery-oriented practice (Borg, 2016). For 30 years, recovery has been, and remains, a significant political subject in the development of western mental health care services (Borg et al., 2013). Many essential values, perspectives, and

principles within recovery are consistent and related to other concepts and perspectives that are well known in a Norwegian context (Borg et al., 2013). "Recovery-oriented care emphasizes the importance of common factors because they provide a foundation through which any and all other interventions may be offered", say Davidson and Chan (2014, p. 676). With this in mind, I move on to looking at common factor models.

2.1.4 Common factor models

Despite the prominent position of the nurse-patient relationship and use of self, the biomedical mode of thinking has prevailed in mental health care. However, there is another mode of thinking worth considering. Saul Rosenzweig originated the common factors notion in 1936 (Duncan, Miller, Wampold, & Hubble, 2010; Rosenzweig, 1936). Common factor models are embedded in "culture, humanism, and traditional healing practices" (Duncan et al., 2010, p. 49). The shared principle in common factor models is that "the specific ingredients stipulated in various treatments are relatively unimportant and instead give primacy to the engagement of a therapist and a client in a healing process" (Duncan et al., 2010, p. 53). This is supported by evidence that suggests that "all treatments intended to be therapeutic are equally effective" (Duncan et al., 2010, p. 56). Even though "distinctions between certain common factors are difficult to make" (Wampold, 2015, p. 272), as many as 89 different factors have been identified (Grencavage & Norcross, 1990). The most prominent factors are, according to Duncan et al. (2010), *clients' active involvement in the therapeutic process* (including placebo effects)*, the therapeutic relationship* (which includes alliance, congruence/genuineness and self-disclosure), and *putting models and techniques in context*. The therapeutic relationship is the most empirically supported common factor and it is considered both a common and specified factor (Weinberger, 2014). The therapeutic relationship's status has been elevated across all major theoretical traditions (Gibson, 2012). In research, terms like *therapeutic/helping/real relationship* and *therapeutic/working alliance* refer to the relationship and its qualities. Examples of literature employing these terms are: *helping relationship* (Borg & Kristiansen, 2004), *therapeutic relationship* (Wampold, 2015), *real relationship* (Duquette, 1993), *therapeutic alliance* (Morvillers & Rothan-Tondeur, 2017; Nienhuis et al., 2016) or *working alliance* (Bordin, 1979; Topor & Denhov, 2012), or simply *alliance* (Kåver & Gröhn, 2012; Wormnes, 2013).

Although common factors challenge the usefulness of therapeutic methods, they do not render such methods useless. Rosenzweig suggested, in his 1936 article on common factors, that certain treatments "are very likely better suited than others to certain types of cases" (Rosenzweig, 1936, p. 413). Acknowledging the healing capacity of common factors does not imply underestimating the significance of therapeutic methods. On the contrary, it is a

“fundamental misunderstanding [...] that the treatment model and the common factors are separate and distinct” (Duncan et al., 2010, p. 143). “Therapy without *any* explanation [for the patient’s distress]—simply a relationship with an empathic therapist—is not sufficient,” insists Laska and Wampold (2014, p. 520). “Explanation and treatment relevant to the patient and the patient’s problem *is* one of the common factors” (Laska & Wampold, 2014, pp. 521-522) and it is one of the necessary factors in a common factor approach (Laska, Gurman, & Wampold, 2014).

The connection between the therapeutic relationship and different treatment approaches might lie in whether they facilitate or hinder development of a therapeutic relationship. Some models of approach (and organizational conditions) seem to facilitate helpful relationships (Topor & Ljungberg, 2016). The contextual model (Wampold, 2015, p. 271) places the therapeutic relationship as a condition for activating three pathways – one of which is “cogent treatment [that] contains certain well-specified therapeutic actions.” This means that all therapies with structure will yield approximately equal effects if they are dispensed within a favorable relational context (Wampold, 2015). Looking at common factors as independent entities “fails to recognize potential relationships between factors in practice” (Fife, Whiting, Bradford, & Davis, 2014, p. 21).

Much literature on common factors revolves around psychotherapy, but there are contributions from other disciplines as well. A scoping review of common factors in community mental health care focused primarily on therapeutic alliance and concluded that “the development of a positive therapeutic alliance is related to better outcomes” (Kidd, Davidson, & McKenzie, 2017). A qualitative study enlisting service users’ experiences identified certain common factors to helpful relationships (Borg & Kristiansen, 2004). While I have not come across much nursing literature using the term common factors explicitly, the therapeutic relationship is, as previously stated, pivotal in mental health nursing.

2.2 Professional boundaries

Gutheil and Brodsky (2011, p. 18) define a boundary as “the edge of appropriate behavior at a given moment in the relationship between a patient and a therapist, as governed by the therapeutic context and contract.” Jones (2016, p. 50) describes boundaries as “the physical and psychological space that a person denotes as his or her own.” In psychoanalysis, professional boundaries “define the parameters of the analytic relationship so that the patient and analyst can be safe while also being spontaneous” (Gabbard, 2016, p. 4). Professional boundaries safeguard the patient and the therapist so that therapeutic regression can occur and the therapist can “contain and process feelings without acting inappropriately on them” (Gabbard, 2016, p. 6). The psychodynamic terms *transference* and *countertransference* describe patients

and professionals' emotional responses to each other (Jones et al., 2016). "Being able to manage transference and counter-transference is very important in boundary management to maintain a professional interpersonal relationship and to deliver appropriate nursing care," claim Jones et al. (2016, p. 51). Patients' wishes for different kinds of relationships with nurses can reflect transference, while nurses' feelings of attraction or liking towards patients can be countertransference reactions (Gallop, 1998b). A point of critique is that the concept of countertransference defines the professional's experience as reactive rather than subjective (Aron, 1991).

The rationale behind professional boundaries is based on the imbalance of power in professional-patient relationships (Jones et al., 2016). The power of nurses comes from "the professional position with access to private knowledge about the patient" (Jones et al., 2016, p. 51). Patients, by nature of their illness, are considered dependent and vulnerable (Jones et al., 2016). Though patients and professionals are of equal worth, they are not equally responsible for the relationship (Damsgaard, 2010). It is the professional's duty to establish and maintain appropriate boundaries (Simon, 1992). "The nurse's role defines and distinguishes the nurse's purpose and duties from those of the patient role," explains Pilette, Berck, and Achber (1995, p. 40), and adds, "it charges the nurse with the responsibility of separating and containing his/her needs separately from the patient's needs." The patient's need for help is the foundation for the professional relationship, not a subjective and emotional attachment as in personal relationships (Kristoffersen et al., 2011).

2.2.1 Boundary theory

Literature on professional boundaries and boundary issues is often referred to as *boundary theory*. Boundary theory spans different disciplines and decades. During the course of this study, I learned that some authors, like Glen O. Gabbard and Thomas G. Gutheil, have contributed significantly to the subject (Gabbard, 2016; Gabbard & Nadelson, 1995; Gutheil & Brodsky, 2011; Gutheil & Gabbard, 1993). They made an important contribution to boundary theory through the differentiation between boundary crossings (which does not harm the patient) and boundary violations (clearly harmful or exploitative) (Gutheil & Gabbard, 1993, 1998), a contribution that has been described as a turning point for the field of boundaries (Pope & Keith-Spiegel, 2008). Furthermore, it became clear that substantial amounts of the literature and research on professional boundaries have focused on the psychotherapeutic setting or other types of consultations where a therapist or physician is alone with a patient (Brooks, Eley, Pratt, & Zink, 2012; Chadda & Slonim, 1998; Epstein & Simon, 1990; Gutheil, 1989; Gutheil & Gabbard, 1993; Norris, Gutheil, & Strasburger, 2003; D. Smith & Fitzpatrick, 1995).

The abundance of literature concerning boundaries in psychotherapy has roots in the traditional psychoanalytic and psychodynamic approaches (Tantillo, 2004). According to Chadda and Slonim (1998), abstinence and non-exploitation of the patient, therapist neutrality, and avoiding dual agency are modern concepts that can be attributed to Sigmund Freud. These concepts are connected to the therapist's role and vary according to type of therapy (Chadda & Slonim, 1998).

Still, quite a few studies have delved into the issue of boundaries in nurse-patient relationships (Baca, 2011; R. J. Campbell, Yonge, & Austin, 2005; Gardner, 2010; Hanna & Suplee, 2012; Manfrin-Ledet, Porche, & Eymard, 2015; Peternelj-Taylor, 2002; Peternelj-Taylor & Yonge, 2003; Pilette et al., 1995; Valente, 2017). These studies provide some clinical examples, but most of them are literature reviews. As I was to find out, empirical research into nurses and various boundary issues appeared to be lacking. This applies to the field of mental health nursing as well. The scarce amount of empirical research might suggest that although textbooks identify professional boundaries in mental health nursing as an important aspect of nurse-patient relationships, professional boundaries are to a certain degree unexplored. Jones, Fitzpatrick, and Drake (2008, p. 357) state that the work of Peternelj-Taylor is at the forefront of "inquiry into nurse-patient relationships and boundary violations." In one article, Peternelj-Taylor (2002) concludes that nurses frequently find themselves in situations that test professional boundaries, and that there are no black and white answers to boundary dilemmas. In another article, Peternelj-Taylor and Yonge (2003) assert that issues related to professional boundaries must be integral to nursing curricula, and that nurses all too often learn about boundaries by trial and error Others who have contributed to exploring professional boundaries in nursing have focused on danger signals/warning signs (Coltrane & Pugh, 1978; Taylor, 1998), self-disclosure (Deering, 1999), nonsexual dual relationships (Gallop, 1998b), sexual boundaries (Baca, 2009), or professional boundaries in general (Armstrong, 1996; Baca, 2011; Gallop, 1998a; Griffith, 2013; Griffith & Tengnah, 2013; Hanna & Suplee, 2012; Henderson, 2004; Holder & Schenthal, 2007; McClunie-Trust, 2016; Norman, 2000; Pilette et al., 1995; Sheets, 2001; L. L. Smith, Taylor, Keys, & Gornto, 1997). Only two have focused on mental health settings specifically (Baron, 2001; Valente, 2017). None of the studies on professional boundaries in nursing mentioned so far is empirical studies. The few empirical studies on boundary issues in nursing that I have found explore professional boundaries in therapeutic relationships (Gardner, 2010), self-disclosure (M. N. Johnson, 1980), intimacy/sexual boundary violations (R. J. Campbell et al., 2005), or review disciplinary cases (Chiarella & Adrian, 2014; Jones et al.,

2008). A systematic literature review from 2015 identified only five publications from the last 20 years related to nursing and professional boundaries (Manfrin-Ledet et al., 2015).

I discovered that the terms self-disclosure and dual relationships were commonly used to describe sharing personal information and having off-hours contact with patients. Although much research on self-disclosure has focused on therapists and one-on-one therapist-patient interactions (Allen & Arroll, 2015; Arroll & Allen, 2015; Audet & Everall, 2010; Barnett, 2011; Beach et al., 2004; Berg, Antonsen, & Binder, 2016a, 2016b; Gibson, 2012; Goldstein, 1994, 1997; Hanson, 2005; Henretty, Currier, Berman, & Levitt, 2014; Henretty & Levitt, 2010; Hill, Mahalik, & Thompson, 1989; Knox, Hess, Petersen, & Hill, 1997; Levitt et al., 2016; Myers & Hayes, 2006; Peterson, 2002; Pinto-Coelho, Hill, & Kivlighan Jr, 2016; Ziv-Beiman, 2013; Ziv-Beiman & Shahar, 2016), some researchers have had a nurse perspective (Ashmore & Banks, 2002; Burnard & Morrison, 1994; Deering, 1999; M. N. Johnson, 1980). Considering that Sidney M. Jourard, who coined the term *self-disclosure*, wrote about nurses in the book *The transparent self* (1971) and did research on self-disclosure among nursing faculty (Jourard, 1959), it can be a bit surprising that self-disclosure seems to have stirred little interest among nurse researchers. Adding the fact that self-disclosure is considered an important nurse intervention (Stuart, 2008, 2013), I found it strange that there were so few research articles about nurse self-disclosure among the results in the database searches I conducted. I believe the reason for this might be that different researchers (in nursing and other disciplines) have used other terms to describe the same phenomenon. Self-disclosure, understood as the sharing of personal information, has been described in empirical research as disclosure of personal experiences (Ljungberg, Denhov, & Topor, 2015, 2017; Moen & Larsen, 2013; Oates, Drey, & Jones, 2017; Shattell, McAllister, Hogan, & Thomas, 2006), as part of vulnerability (Bachmann, Michaelsen, & Vatne, 2016), integral to being human or personal in nurse-patient relationships (Hem & Heggen, 2003; Topor & Denhov, 2015), and as an aspect of being friendly professionals (Jackson & Stevenson, 2000).

The literature on dual relationships (also known as multiple relationships) is marked by the attention to sexual boundary violations that peeked in the 1980's and early 1990's (Gutheil & Brodsky, 2011; Gutheil & Gabbard, 1992). Dual relationships can be sexual or romantic, but they can also be non-sexual or non-romantic (Kagle & Giebelhausen, 1994; Moleski & Kiselica, 2005; Pearson & Piazza, 1997; Reamer, 2003; Sawyer & Prescott, 2010; Zur, 2001). Even if sexual dual relationships are generally advised against, there is little consensus about dual relationships in general. A Chinese study summarized the lack of consensus well. The Chinese study pointed out that different scholars vary in attitudes towards dual relationships, some argue that dual

relationships have negative outcomes, while others argue that certain dual relationships are either therapeutic, inevitable or beneficial (Deng et al., 2016). Nurses have been warned against engaging in dual relationships, both sexual and non-sexual, for decades (Coltrane & Pugh, 1978; Gallop, 1998b). Empirical studies have explored sexual (R. J. Campbell et al., 2005) or non-sexual (Anderson & Kitchener, 1996) dual relationships separately, included both (Borys & Pope, 1989; Deng et al., 2016; Lamb, Catanzaro, & Moorman, 2004), or have not specified type of dual relationship (Brooks et al., 2012; Gonyea, Wright, & Earl-Kulkosky, 2014). The last couple of decades, there seems to be increased focus on how dual relationship issues present in rural areas (Brocious et al., 2013; Brooks et al., 2012; Brownlee, 1996; C. D. Campbell & Gordon, 2003; Gonyea et al., 2014; Halverson, 2014; Piché, Brownlee, & Halverson, 2015; Pugh, 2006; Scopelliti et al., 2004). This focus lacked in earlier research on ethical dilemmas in rural mental health care (Kitchener, 1988). Unfortunately, none of the recent research involves mental health nursing in rural areas, as far as I have seen.

The significance of context has not gone undetected in extant literature on professional boundaries. Gutheil and Gabbard (1998, p. 411) asserted that "thinking about boundaries can lead one to an absurd end point, unless one understands the critical role of the context in which behavior occurs." Self-disclosure is a "very difficult and highly individualized and subjective process," noted Goldstein (1997, p. 47), and an exploration of therapist self-disclosure in theory, research and practice found that the socio-cultural context influenced therapist self-disclosure (Gibson, 2012). The context of the therapist-patient relationship influenced which self-disclosures that were considered appropriate (Gibson, 2012). Context informs the decision to be personal and to transgress boundaries, but it also shapes the meaning of the behaviors. Context decides whether the behavior is acceptable in the specific situation, according to Glass (2003). The same behavior may "constitute either a boundary crossing or a boundary violation, depending *entirely* on the context in which it occurs," write Gutheil and Gabbard (1998, p. 411). The impact of boundary transgressions must therefore be assessed on a case-by-case basis that takes into account the context and the facts of the specific situation (Gutheil & Gabbard, 1993). Pope and Keith-Spiegel (2008) mention how culture, age, gender, therapy setting, patients' diagnosis or condition and theoretical orientation affect the perception, impact and course of boundary crossings in psychotherapy. Regarding patients' diagnosis, boundary theory identifies patients with borderline personality disorder as a risk factor for boundary transgressions. Patients with borderline personality disorder can experience borderline rage (which scares professionals from setting boundaries in fear of the patient's volcanic response), neediness and/or dependency (which can foster professional's

overinvolvement), boundary confusion (which confuses the professional as well), and manipulativeness and entitlement (which makes the professional deviate from usual practice) (Gutheil, 1989). In addition, Gutheil (2005) problematized boundary issues that arise in relation to histrionic and dependent personality disorder and antisocial personality disorder. He states that “empirically, the cluster A group, marked by a tendency toward detachment, is less likely to be involved in a boundary issue than the other two clusters” (Gutheil, 2005, p. 91). Lower levels of initial symptomology in patients have been associated with more therapist self-disclosure (Kelly & Rodriguez, 2007).

Different treatment ideologies promote professional boundaries differently. The therapeutic approach is a type of context that has received notable attention in boundary theory and research. Therapeutic ideologies increase the complexity of boundary transgressions (Gutheil & Gabbard, 1993). The different theoretical positions on therapist self-disclosure is an example of how varied treatment approaches influence professional boundaries. In general, psychodynamic theories promote not self-disclosing, humanistic theories embrace self-disclosure, behavioral/cognitive theories favor self-disclosure that serves as modelling for patient self-disclosure, feminist theories support appropriate use of self-disclosure, while multicultural theories advocate self-disclosure – especially in professional relationships with patients from different sociocultural backgrounds and alternative lifestyles (Hill & Knox, 2002).

Other contextual aspects are class, sexuality (O'Leary, Tsui, & Ruch, 2012) and ethnicity (Gibson, 2012). While some list different contextual factors, others mention that context is important without providing much additional explanation or detail – like two studies on counselors that found contextual factors and circumstances important to dual relationship issues (Nigro, 2004; Nigro & Uhlemann, 2004). Some cultural norms can make professional boundaries more difficult, like the Chinese who place human relationships and mutuality over reason, making dual relationships harder to avoid (Deng et al., 2016). Different cultural practices and work in rural settings make it seem impossible to “maintain a strictly professional separation from clients and avoid any social and personal exchanges” (O'Leary et al., 2012, p. 142). Rural practice puts added strain on professional boundaries, according to a number of studies (Brooks et al., 2012; Brownlee, 1996; Epstein, Simon, & Kay, 1992; Nigro & Uhlemann, 2004). Rural therapists have indicated concern about in which context they knew potential clients – making distinctions between knowing them personally or professionally (Gonyea et al., 2014). Unavoidable dual relationships are prevalent in rural areas (C. D. Campbell & Gordon, 2003) and physicians in one study compared rural practice to living in a

fishbowl: "The smaller the town, the less choice they had in whether or not to interact with patients in social or community settings" (Brooks et al., 2012, p. 1092).

Boundary issues have raised awareness for a long time within mental health care and especially within psychotherapy. A 1978 article on "danger signals" in nurse-patient relationships warned nurses against seeing patients during off hours, being possessive about patients and answering personal questions in vague manners (Coltrane & Pugh, 1978). A historic account can be found in Gutheil and Brodsky (2011, p. 7) who amongst other things describe a historical development that includes the appearance of the term *boundary violations* in the 1970's and a shift in the 1990's from overly restrictive warnings to an increased appreciation for "exercising appropriate flexibility and creativity in the patient's best interest." Later developments included the differentiation between *boundary violations* and *boundary crossings* by Gutheil and Gabbard (1998). Boundary crossings are thought to be benign and beneficial to the patient, whereas boundary violations are clearly harmful or exploitative (Gutheil & Gabbard, 1998). The difficulty with deciding whether an action or behavior constitutes a crossing or a violation can result in a "defensive inflexibility" in professional boundaries that interferes with flexible treatment (Glass, 2003, p. 431). Extant literature on boundary issues operate with a plethora of definitions of different types of boundary transgressions. Usual categories include sexual boundary violations, dual relationships, gifts and services, self-disclosure, and physical contact (Gabbard & Nadelson, 1995; Gutheil & Brodsky, 2011). Glass (2003) refers to a spectrum of boundary crossings where different interventions are more or less transgressions of therapeutic boundaries. One study that explored the spectrum of boundary violations in nurse-patient relationships found that behaviors spanned from minor infringements (like inappropriate compliments) to sexual intercourse (Chiarella & Adrian, 2014). Of the 29 complaints the study examined, 18 of the nurses worked in mental health care or methadone clinics (Chiarella & Adrian, 2014).

The same boundary transgressions can be beneficial to one patient, but harmful to another (Pope & Keith-Spiegel, 2008). "Depending on the nurse's and patient's gender, culture, age, and ethnicity, certain behaviors may be perceived differently than intended," according to Hanna and Suplee (2012, p. 41). The degree of exploitation depends on what the patient subjectively experiences (Gutheil & Gabbard, 1992) and boundary crossings that seem harmless to both the patient and the nurse can be perceived differently by others (Hanna & Suplee, 2012). In Goldstein's (1994) description of certain situations that can contraindicate self-disclosure from professionals, several items refer to the patient. Goldstein (1994) advise against self-disclosure when the patient's boundaries and reality testing are blurry, when the patient

tends to focus on other's needs rather than his or her own, when needs for mirroring or idealizing are primary and if self-disclosure will burden the patient. Patients' vulnerability to boundary issues can be increased by enmeshment with the professional, retraumatization from earlier abuse, the repetition compulsion, shame and self-blame, confusing transference with true love, dependency, narcissism, and masochism (Gutheil, 2005). The patient's role in boundary violations has received less attention than the professional's role (H. Johnson, Worthington, Gredecki, & Wilks-Riley, 2016). I suspect the reason for this is that professionals bear the responsibility of establishing and maintaining appropriate boundaries. Gutheil and Simon (2002, p. 586) state that even though "patients may request, propose, initiate, or even blunder into boundary transgressions," the professional remains responsible for establishing and maintaining professional boundaries.

The damaging effects of sexual boundary transgressions have made the medical professions pay more attention to professional boundaries (Gabbard & Nadelson, 1995). Although opinions differ on the topic, some argue that there is a *slippery slope* leading from harmless transgressions to sexual boundary violations (Gutheil & Brodsky, 2011). Sexual relationships with current patients are generally considered unprofessional (Moleski & Kiselica, 2005), while there are divided opinions on sexual relationships with former patients (Bird, 2013; Reamer, 2003). One study from Canada reported that nurses strongly agreed it was inappropriate to date or have sexual relationships with current or former patients (R. J. Campbell et al., 2005). Sexual dual relationships are deemed inappropriate across disciplines (Gardner, McCutcheon, & Fedoruk, 2015), including nurses (Gallop, 1998b), social workers (Reamer, 2003; Strom-Gottfried, 1999), psychologists (Lamb et al., 2004) and counsellors (Nigro & Uhlemann, 2004). There are different stances on whether sexual relationships with former patients are unethical. Responses from therapists in one study yielded 3.9 percent who had engaged in a sexual dual relationship with a former client, while 0.4 percent self-reported to have had sexual relations with a current client (Borys & Pope, 1989). Some advocate a period of quarantine, e.g. five years for rehabilitation counselors (Cottone, 2010). In one study on counsellors, only half of the respondents assessed sexual relationships with a patient two years after termination as *not* ethical (Nigro & Uhlemann, 2004).

Although there seems to be a consensus on a general level in differentiating between sexual and nonsexual boundary violations, there is more controversy regarding defining specific boundary transgressions (Glass, 2003). The trouble with delineating self-disclosure is an example of this (McCarthy Veach, 2011). In addition, there is little consensus regarding whether nonsexual dual relationships are ethical (Anderson & Kitchener, 1996; Gallop, 1998b).

In a study on dual relationships between therapists and clients, 26.5 percent of respondents admitted to becoming friends with former patients (Borys & Pope, 1989). Favoritism, attraction, self-disclosure, accepting gifts, and adopting a rescuer role are some of the other boundary transgressions that professionals working in mental health care are unsure about (Gardner et al., 2015).

The term boundary usually refers to geographic boundaries, but also has a long history within the discipline of psychoanalysis (Gabbard, 2016). Boundaries "demarcate the line where we cease and others begin" (Epstein, 1994, p. 15). Boundaries between people "validate the uniqueness and individuality of others" (Epstein, 1994, p. 16). Psychological boundaries may be physical (like touch) or mental representations (like feelings) (Epstein, 1994; Jones et al., 2016). The term's current use is connected to the intrapsychic focus of psychoanalysis, but has been expanded to include the interpersonal dimension between patients and professionals (Gabbard, 2016). This means that the concept *professional boundaries* defines the limits of the relationship between a professional and a patient. Professional boundaries seek to protect both parties in the professional-patient relationship (Bird, 2013). Gabbard (2016, p. 4) argues that the concept is often misunderstood to support a "rigid, robotic, and remote" attitude, while the intent is quite the opposite – to provide a safe frame for spontaneity for both in the professional-patient relationship. The term boundary has received criticism for not being well defined (Gabbard & Nadelson, 1995) and not describing the phenomenon that it refers to accurately, but so far, it has not been replaced (Austin, Bergum, Nuttgens, & Peternelj-Taylor, 2006).

2.2.2 Legal role boundaries

In Norway, the Health Personnel Act regulates the nurse-patient relationship and professional boundaries. Section 4 on responsible conduct is especially relevant ("Lov om helsepersonell m.v.," 1999). Section 4 states in its first paragraph that: "Health personnel shall conduct their work in accordance with the requirements to professional responsibility and diligent care that can be expected based on their qualifications, the nature of their work and the situation in general" ("Lov om helsepersonell m.v.," 1999). The Health Personnel Act provides the Norwegian Board of Health Supervision (NBHS) with the authority to sanction infringements of the act. NBHS claims that close personal relationships between professionals and patients conflicts with the demands of section 4 (Statens helsetilsyn, 2012a). Section 56 in the Health Personnel Act states that the NBHS can give warnings to professionals who intentionally or negligently endanger the safety of the health service or impose a considerable burden on patients ("Lov om helsepersonell m.v.," 1999). Section 57 states that authorizations or licenses

may be revoked if the holder is unfit to practice his or her profession in a responsible manner for reasons of gross lack of professional insight or irresponsible conduct ("Lov om helsepersonell m.v.," 1999). The NBHS considers each disciplinary case by itself and assesses whether actions are responsible or not based on the facts of the particular case (Statens helsetilsyn, 2016).

In September 2015, I requested access to the NBHS' decisions in disciplinary cases regarding dual relationships involving nurses and/or mental health care. In December 2015, I received copies of eight disciplinary case decisions. One did not provide any coherent information because of the amount of redacted text. In June 2017, I requested access to disciplinary cases regarding dual relationships in mental health care in the period from December 2015 to June 2017. In July 2017, I received 12 disciplinary case decision copies. The disciplinary case documents are exempt from public disclosure, but the NBHS provides anonymized examples on their website (Statens helsetilsyn, 2018a). There was some overlap between the disciplinary case documents I received and the anonymized examples on their website (1 case). In addition, The Norwegian Board for Health Personnel (NBHP), who handles disciplinary case complaints, used to publish anonymized complaint case decisions. In June 2017, I found 15 complaint cases regarding the NBHS's decisions on disciplinary cases involving dual relationships. Unfortunately, after NBHP redesigned their website, the decisions do not seem to be available online anymore. While the 15 disciplinary cases were still available online, I reviewed them together with the 19 case decision copies and the 6 online case presentations from the NBHS (39 cases in total given the one case overlap). I examined the stated facts of the disciplinary case, assessments and decisions. In august 2018, I searched the NHBS online disciplinary case examples and found three additional cases involving professional boundaries. One of these related to nurses and/or mental health care.

This review of disciplinary cases is not part of the study's data, but I will use examples from the disciplinary cases in the discussion of the study's result. The disciplinary cases provide important examples, especially related to the patients' perspectives, which the study's data do not cover. I will provide references to disciplinary cases that are publicly available. In addition, I will include some general reflections and examples based on the review as a whole and add specific references when possible, but please note that the general reflections and examples are in accordance with the NHBS's assessments in disciplinary cases exempt from public disclosure as well.

The NBHS's decisions in disciplinary cases regarding dual relationships reveal that intimate and/or sexual relationships often lead to withdrawal of license, while friendships result in a warning (Unhjem & Vangen, 2017). The NBHS assessments hold professionals responsible for managing professional boundaries and assert that professionals should not use relationships with patients to satisfy their own emotional, social or sexual needs (Statens helsetilsyn, 2014, 2016, 2017, 2018b). Such relationships can signal, in the NBHS's opinion, a gross lack of professional insight, irresponsible conduct and/or behavior incompatible with professional conduct. The NBHS insists that even though professionals and patients can experience themselves as equal, the patient depends on the professional and the relationship is asymmetrical in terms of power and vulnerability (Statens helsetilsyn, 2014, 2018b). The NBHS indicate that patients with mental illnesses are especially vulnerable (Statens helsetilsyn, 2018b). The relationship imbalance will transfer to the privatized relationship as well, and professionals should not engage in private relationships with current or former patients. This is regardless of whether the patient experiences the relationship as positive and regardless of who initiates the relationship – the NBHS note that it is not unusual for patients to seek personal relationships with professionals (Statens helsetilsyn, 2014). There is no clear limit as to how much time must pass before it is sensible to enter private relationships with former patients, according to the NBHS. The nature and extent of the treatment, treatment course and the professional-patient relationship decide what the appropriate amount of time is. The NBHS recommends that professionals in community based health services are especially cautious about not confusing professional and personal roles. Boundary violations such as dual relationships pose threats to patients' health, integrity, dignity and rights. Professionals risk inflicting patients with additional trauma (Statens helsetilsyn, 2014). Making relationships private or sexual entails a severe breach of trust and betrays the patient (Statens helsetilsyn, 2012b).

The NBHS is adamant about the importance of trust. Boundary violations damage trust in individual treatment relationships as well as trust in the health care system (Statens helsetilsyn, 2017). This is because professionals not only represent themselves, but also represent their professions and the health care system (Statens helsetilsyn, 2018b). The NBHS states that patients, next of kin, colleagues, employers and others must be able to trust that professionals do not use their position for profit or to satisfy their own needs (Statens helsetilsyn, 2018b). The NBHS revokes licenses in order to ensure quality and the public's trust in the health services in addition to protect current and future patients against unprofessional conduct (Statens helsetilsyn, 2016, 2018b). Patients should be able to trust that health services

are provided on a basis of objective criteria and professional assessments of the patients' needs for health care (Statens helsetilsyn, 2016, 2018b).

The Health Personnel Act addresses other boundary issues than dual relationships as well. The Health Personnel Act stipulates a ban relating to receiving gifts while acting in a professional capacity in Section 9. The gift ban includes gifts, commissions, services and other benefits as well, as long as these are suitable to affect the professional's services unduly ("Lov om helsepersonell m.v.," 1999). Some of the Norwegian Board of Health Supervision's cases fall under the General Civil Penal Code. The General Civil Penal Code's sections 295 and 296 cover situations where a person misuses his or her position, or a relationship of dependence, to aid and abet another person to engage in sexual activity (Justis- og beredskapsdepartementet, 2018). One of the nurses whose license was revoked by the NBHS, had been indicted for violating section 295 (Abuse of unequal power relationship, etc.), but the case was dismissed (Statens helsetilsyn, 2018b). The NBHS assesses cases independent of judicial inquiries (Statens helsetilsyn, 2018b), but legal documents can be part of the facts of the case.

Similar regulations of professional boundaries can be found internationally (Griffith & Tengnah, 2013). The most common avenues of evaluating claims of boundary violations are, according to Gutheil and Brodsky (2011, p. 259), "complaints to ethics committees of professional associations, complaints to state professional licensing boards, and civil litigation."

2.2.3 Professional codes of ethics and guidelines

Ethical guidelines for nursing practice contribute to define what responsible and irresponsible conduct in a given situation is. Ethical guidelines can therefore be important in assessing professional boundaries. Professional ethics for nurses are described in the ethical codes of conduct from the Norwegian Nurses' Organization and the International Council of Nurses' Code of Ethics for Nurses (Norsk sykepleierforbund, 2011). Neither the Norwegian ethical guidelines nor the ICN code of ethics addresses professional relationship boundaries specifically. In contrast, the National Council of State Boards of Nursing describes red flag behaviors in their guide to professional boundaries (National Council of State Boards of Nursing, 2011) and the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct include guidelines regarding exploitative relationships, conflict of interest, multiple relationships and sexual harassment (American Psychological Association, 2017).

In biomedical fields, such as mental health care, certain virtues are essential to professional roles, while some vices are unacceptable (Beauchamp & Childress, 2013). Several virtues are considered necessary to support and promote care and caregiving: compassion, discernment, trustworthiness, integrity, and conscientiousness (Beauchamp & Childress, 2013). Some of these virtues' characteristics can be similar to important ethical principles, such as respectfulness, nonmalevolence, benevolence, justice, truthfulness, and faithfulness. Ethical principles apply to professional boundaries in different ways, e.g. how boundary transgressions may cause harm to patients (Gutheil & Simon, 2002). Patient dignity and autonomy are fundamental ethical principles relevant to professional boundaries (Aravind, Krishnaram, & Thasneem, 2012). Benevolence, nonmalevolence, respect for autonomy, and justice are regarded the most important ethical principles for nursing (Nortvedt, 2012). These are reflected in the ethical guidelines for nurses in Norway (Norsk sykepleierforbund, 2011).

In Norway, there are 29 licensed health professions. They include, among others, nurses, midwives, physicians and psychologists. Looking into each profession's ethical codes of conduct, I found that the nurses' codes of ethics were just one of 14 that do not address professional boundaries explicitly. Among the ones that do address boundary issues, are physicians, ambulance workers, bioengineers, physical therapists, health workers, practical nurses, chiropractors, social workers, prosthetists, orthoptists and psychologists. The ethical principles for Nordic psychologists address professional boundaries in terms similar to the terms used by The Norwegian Board of Health Supervision in their assessments of boundary violations. The psychologists' ethical principles have a section about role conflicts and exploitation (Norsk psykologforening, 1998). The section instructs psychologists to strive for conscientiousness about own needs, attitudes and considerations, and about his or her role in the relationship with the patient. The section states that psychologists should not abuse their power and position by exploiting the patient's dependence and trust. In addition, psychologists must avoid non-professional relationships with patients that can reduce the professional distance and lead to conflicts of interest or exploitation. Psychologists should be attentive to how intimacy and sexuality affect the relationship between the psychologist and the patient both directly and indirectly. Psychologists should avoid privatizing and sexualizing patient relationships. The psychologists' ethical principles assert that sexual intercourse with patients must not occur (Norsk psykologforening, 1998). The ethical codes of conduct for physicians (Den norske legeforening, 2015) state in section 7 that physicians must not exploit patients sexually, economically, religiously or in any other way. Section 7 proceeds with stating that a patient's consent does not exempt the physician from responsibility and that a physician must

not engage in sexual relationships with a person that he or her is a physician to (Den norske legeforening, 2015). The ethical codes of conduct for physical therapists is similar, stating that the physical therapist must not engage in sexual relationships with or make sexual advances towards patients and that a patient's consent does not absolve the physical therapist's responsibility (Norsk fysioterapeutforbund, 2015). Other ethical codes of conduct address the issue less specifically, for example by stating that no one must exploit or profit from their relationship with patients (Ambulanseforbundet, 2016)

The Norwegian Council for Nurse Ethics asserts that ethics are not standards (Dolonen, 2018). Ethics are created in relations with others in varied situations. According to the council, it is difficult to give categorical answers to questions about whether it is wrong to develop relationships or friendships with patients (Dolonen, 2018). The Norwegian Council for Nurse Ethics refers to applying common sense and to closely examining the values that are at stake in particular situations. The Council finds it clear that patients who suffer from severe mental illnesses can be more vulnerable than patients admitted once for breaking an arm or such (Dolonen, 2018). In any case, it is important to consider the values at stake and always to act in the patient's best interest. The Norwegian Council for Physician Ethics have stated that although sexual dual relationships are prohibited according to section 7 in the physicians' ethical codes of conduct, some dual relationships are acceptable depending on the specific circumstances (Hytten, 2011). The physicians' council claims that non-sexual relationships with former patients are not prohibited as long as the relationships are not exploitative. Whether sexual or romantic relationships are acceptable depends on the nature of the physician-patient relationship. A surgeon can have a romantic relationship with a former patient, while a psychotherapist is prohibited from having such relationships with patients who have received long-term therapy (Hytten, 2011). The professions address professional boundaries differently. Some address boundary issues quite specifically, like physicians. The differences between ethical codes of conduct can be related to how the professions deal with patients. Professions that encounter patients in traditional therapy settings where the professional and the patient meets one-to-one and defined in time and place seem to address boundary issues more directly. In any case, ethical codes on professional boundaries have been criticized for paying little attention to why and how boundaries are set (O'Leary et al., 2012).

Some researchers have developed guidelines and models to supplement legislation and professional codes of ethics. A decision-making model for psychologists to avoid exploitative dual relationships focuses on three dimensions which are said to be basic and critical to the ethical decision-making process (Gottlieb, 1993). The dimensions are power (the degree of

power that the professional has in relation to the patient), duration of the relationship (power increases after time) and clarity of termination (likelihood of further professional contact) (Gottlieb, 1993). Guidelines addressing professional boundaries often encourage professionals to consider whether boundary crossings would be helpful or harmful and to seek guidance from colleagues, ethics codes, legislation and professional guidelines (Pilette et al., 1995; Pope & Keith-Spiegel, 2008). It is also recommended to document any boundary crossing (Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007; Pope & Keith-Spiegel, 2008). The Exploitation Index (Epstein & Simon, 1990) is a questionnaire aimed at helping therapists assess their behavior and attitudes, which can also be used in group discussions or as a teaching aid. The Exploitation Index consists of 32 questions covering seven subcategories: generalized boundary violations, eroticism, exhibitionism, dependency, power seeking, greed, and enabling (Epstein & Simon, 1990). While it is one of the more extensive guidelines, that I have come across, I have not found many studies using The Exploitation Index to assess boundary violations. An exception is the authors' own survey of boundary violations in psychotherapy, where one of the findings was that 18.8 percent of the surveyed psychiatrists reported to have pursued relationships with former patients (Epstein et al., 1992). In addition, a modified index has been developed for nurses (Pilette et al., 1995).

Some guidelines are aimed at specific boundary issues, such as self-disclosure (Hill & Knox, 2002), while others aim at boundary issues in general (Reamer, 2003). Guidelines differ in their agendas. Some are meant to be tools for reflection (how to think about professional boundaries), some are instructive (how to manage professional boundaries), while some are analytic (how to identify boundary issues). Because of considerable variability in the application of professional boundaries in specific professional-patient relationships, "only guidelines, not standards, can be promulgated" (Simon, 1994, p. 514). The problem of guidelines is the same as with ethical codes of conduct and legislation. Guidelines that are too specific risk being irrelevant because contexts differ. Guidelines that are too general risk being too superficial to provide any useful guidance.

2.3 Care ethics

Care ethics provide a relevant perspective to understand what it means to be professional, personal and private within the dynamics of nurse-patient relationships. Care ethics' and mature care's acknowledgement of the interests of all affected parties opens up for recognizing the interests of nurses, colleagues and other people in the wider relational context – interests that are play into and are affected by nurses' professional boundaries. In this chapter, I will give a brief introduction to care ethics and mature care. I will concentrate on two

contributions to care ethics in particular, Carol Gilligan's idea of *a different voice* and Nel Noddings' thoughts on *the maternal factor*.

Care ethics challenge the traditional perspectives on caring relationships. Care ethics emphasize connectedness, dependency and vulnerability as essential normative features (Nortvedt, Hem, & Skirbekk, 2011). Proponents of care ethics often criticize traditional theories that emphasize principle-driven professionalism (Beauchamp & Childress, 2013). Gilligan has been especially influential in this respect, by stating that there are two modes of moral thinking where one is an ethic of rights and justice, while the other is an ethic of care that acknowledges the female experience of responsiveness and interconnectedness (Beauchamp & Childress, 2013; Gilligan, 1982). By studying women, Gilligan saw that moral problems arose from "conflicting responsibilities, rather than from competing rights", and a contextual and narrative mode of thinking (rather than formal and abstract) was what resolved moral problems (Gilligan, 1982, p. 19). "Gilligan listened to the experiences, concerns and deliberations and observed the development of ordinary women facing real life challenges," notes Pettersen (2008, p. ix). The different voices of women asserted the "relational nature of all human experience" (Gilligan, 2011, p. 104). Gilligan's research became "an important source for the development of a modern ethics of care" (Pettersen, 2008, p. x). Later developments within feminist ethics have included discussing, developing, refining and applying the ethics of care to different fields, including social politics and global ethical challenges (Pettersen, 2008).

Noddings built a philosophical argument for an ethic of care on the concept of *natural caring* in her 1984 book *Caring: A feminine approach to ethics and moral education*. The second edition was released with an edited subtitle – *A relational approach to ethics and moral education*, that better captured what Noddings intended to convey (Noddings, 2013). Similar to Gilligan, Noddings' relational approach involves rooting care in women's experiences (Noddings, 2013). Noddings accentuates how the language of mothers concentrate on "relationships, needs, care, response, and connection, rather than principles, justice, rights, and hierarchy" (Noddings, 2013, p. xiv). Self-interest and maternal instinct are two evolutionary paths to morality, writes Noddings (2013). She claims that humans relate to one another in groups and communities characterized by *natural caring* – a social state in which "people respond naturally to one another's needs and feelings" and which originates in maternal instinct (Noddings, 2010, p. 17). When natural caring fails, people can draw upon their memories of caring encounters, an ethical ideal of caring (Noddings, 2010). "Natural caring precedes and establishes a model for ethical caring" and is a preferred social condition (Noddings, 2010, p. 169).

Although care ethicists emphasize the female, feminine and maternal, an ethic of care is not a women's ethic. "Care and caring are not women's issues, they are human concerns," insists Gilligan (2011, p. 23). The different voice is characterized not by gender but by theme (Gilligan, 1982, 2011). Some important male thinkers, such as Hume, have thought "in terms congenial to an ethics of care" (Slote, 2007, p. 3). Care ethics is a *human* morality (Slote, 2007). "Within a *patriarchal* framework, care is a feminine ethic. Within a *democratic* framework, care is a human ethic," states Gilligan (2011, p. 22). Care ethics is "a feminist ethic, an ethic that guides the historic struggle to free democracy from patriarchy" (Gilligan, 2011, p. 175).

Gilligan's work described three types of care in the development of the ethic of care, *selfish care*, *altruistic care* and *mature care* (Gilligan, 1982; Pettersen, 2008). Mature care "focuses on the dynamics of relationships and dissipates the tension between selfishness and responsibility through a new understanding of the interconnection between other and self" (Gilligan, 1982, p. 74). In contrast to selfish care and altruistic care, mature care balances the interests of self and others (Pettersen, 2008). Related others include both professional and personal relationships, strangers and distant others (Pettersen, 2008, p. 114). "A moral agent who takes into account both her own and other's needs in considered moral judgments can be called a mature moral agent", claim Hem, Halvorsen, and Nortvedt (2014, p. 796). Maturity related to nursing means that "the nurse has developed into a person who has the capacity to take both perspectives at the same time—both contact with herself and contact with the patient" (Hem & Pettersen, 2011, p. 74). Hem (2008, p. 104) challenges the ideal of altruism and discusses whether mature care is "more specific and constitutes a 'thicker' theory which is more contextually sensitive than the altruistic notion."

Care ethics and mature care represent a perspective that is sensitive to the relational and contextual premises for moral actions. I believe this sensitivity is vital to understanding and guiding boundary decisions in nurse-patient relationships in mental health care. Professional boundaries are indeed relational and contexts matter.

3 Research design and methods

The study's purpose, *to explore nurses' perceptions of and experiences with being professional, personal and private in nurse-patient relationships in mental health care*; resonated with a common aim of qualitative research methods. Qualitative research often seek "to understand, describe and interpret social phenomena as perceived by individuals, groups and cultures" (Holloway & Galvin, 2017, p. 3). The qualitative research design I have chosen for the study corresponds with the ideas of *hermeneutic phenomenology*. Hermeneutics is "the theory of interpretation and developed into its present form as the theory of the interpretation of meaning" (Holloway & Galvin, 2017, p. 223). The study is in line with Gadamer's view; seeing hermeneutics as an approach, not as a specific method (Debesay, Nåden, & Slettebø, 2008). While the hermeneutical orientation underpin the study, it is most discernable in the choice of method of analysis and the emphasis on reflexivity and the researcher's position.

Although the word I used in the study purpose (explore) might be associated with quantitative research, it is also used to describe how qualitative researchers "explore the behaviour, feelings and experiences of people" (Holloway & Galvin, 2017, p. 3). Qualitative research can develop knowledge about people's thoughts, expectations, motives and attitudes, according to Malterud (2011, p. 27). In my study, I wanted to understand more about what it meant to nurses to be professional, personal and private. I felt existing descriptions lacked detail and I hoped a qualitative approach would open up for more nuanced descriptions. Qualitative research is preferable when a complex and detailed understanding of a phenomenon is needed (Creswell & Poth, 2017, p. 45). The study's research questions helped with guiding the study's purpose through actualizing different angles of the purpose.

The term, *thick description*, is associated with data stemming from qualitative research and thick, or *rich*, descriptions depend on the researcher's immersion in the field and detailed and varied notes (Bazeley, 2013, pp. 376-377). An in-depth understanding of behaviors is possible to gain through such rich descriptions (Bourgeault, Dingwall, & De Vries, 2010). Thick descriptions involve "detailed portrayals of the participants' experiences, going beyond a report of surface phenomena to their interpretations, uncovering feelings and the meanings of their actions" (Holloway & Galvin, 2017, p. 7). I wanted to develop new descriptions of being professional, personal and private that was relevant to nurses' practice in mental health care. A qualitative approach allows for a literary, flexible writing style (Creswell & Poth, 2017, p. 45), which I considered suited the intentions of the study well.

While working on my master thesis in criminology, I conducted qualitative interviews with 14 prison officers. I enjoyed interviewing immensely. I felt privileged by gaining insight into something that others rarely are privy to and the prison officers' openness awed me. The experience was inspiring and initially I planned to stick to individual interviews in my PhD study as well. However, the plan changed. My supervisors encouraged me to include different data sources, so I planned to include participant observation and focus group interviews in addition to individual interviews. Because mental health care is provided on three organizational levels: community mental health care, district psychiatric centers and specialist mental health care (Malt, 2018), I wanted to include nurses who worked at different levels.

About six months into the study, main supervisor Professor Vatne and I got the chance to talk to Professor Catherine Chesla (University of California, San Francisco, School of Nursing) about my study. Professor Chesla suggested observing and interviewing all the participants. In addition, she recommended observing every participant twice and for about four hours each time. The talk with Professor Chesla was important to the final plan for the study, which was that I would observe all participants twice, interview each participant twice, and then the participants would take part in one focus group interview.

Overall, these considerations led to the study becoming *a qualitative multisite study with source triangulation*.

3.1 Research context

Mental health care in the Nordic countries share the same development trends: dismantling large institutions, sectored services with outpatient treatments and ambulatory services (Malt, 2018). Asylums became downsized and decentralized services like district psychiatric centers and community based services increased (Norvoll, 2012). Mental health nurses have had an important part in institutional psychiatry after the 1960's and 1970's, and they have become an invaluable resource in community health care following the extensive deinstitutionalization the last couple of decades (Kringlen, 2007).

The study took place in one of the small towns and a neighboring village in Mid-Norway and included nurses from all the three levels: community mental health care, district psychiatric centers and specialist mental health care. The participating psychiatric units (including the district psychiatric center) and districts provide mental health care services to the inhabitants of the municipality and neighboring municipalities.

Instrumental skills and use of technology can characterize nursing practice to a larger degree in acute medical units, while long-time care and home-based care involve more personal

relationships (Kristoffersen et al., 2011, p. 87). Persons with severe mental illness can require help from mental health services for long periods, and nurses in both specialist and community health services may have relationships with patients that span decades. The issue of more personal relationships therefore applies to mental health nursing in both specialist and community mental health care.

3.1.1 Specialist mental health care

Nurses from four different psychiatric units, including both open and closed units, participated in the study. The four psychiatric units belonged to the same hospital trust in Mid-Norway. The hospital trust provides mental health care services at several different locations including cities, towns and villages. Most mental health care institutions have units for inpatient care and out-patients' clinics (Aarre, 2018b, p. 65). Some provide ambulatory services as well.

The nurse-patient ratio in these psychiatric units varied across day, evening and night shifts and type of psychiatric unit. Sometimes there was a nurse-patient ratio at 1:1; while other times the ratio was 1:3. While working as a nurse educator, I have supervised students at two of these psychiatric units. As a nurse, I have worked at one of the psychiatric units 12 years before the PhD study began (mostly nightshifts for a couple of months in one summer). The psychiatric unit was located elsewhere at the time, and I did not recognize any of the staff working there.

3.1.2 Community mental health care

Nurses from three different districts in Mid-Norway participated in the study. In community mental health care, an example of the nurse-patient ratio was 1:15 in one of the districts. Patients attended to by nurses in community mental health care usually met with their nurse weekly and some had contact with the nurse on a daily basis. Many patients with mental illnesses are in need of long-term care from primary health services (Snoek & Engedal, 2008).

Interaction between nurses and patients in community mental health care often take place outside institutions and clinics, much like assertive outreach teams and patients who meet in patients' homes, shopping malls, or cafés (Almvik, Sagsveen, Olsø, Westerlund, & Norvoll, 2011). Nurses working in outpatient settings like community mental health care, are likely to assess an interpersonal model of care more favorably than nurses working in inpatient settings, claim Carlyle et al. (2012).

3.2 Participants

Following the study's purpose and research questions, inclusion criteria listed any nurse who worked in mental health care as a potential participant. I assumed that the hospital trust's local psychiatric units and the municipality's community mental health districts could provide

a sufficient number of participants. By choosing one of the local small towns and neighboring areas, participants could be recruited through my professional (working as a nurse educator) and personal (having family who worked within mental health care) networks and travel expenses (both time and money) could be kept at a minimum.

There are three considerations that are important to a purposeful sampling strategy in qualitative research: Whom to select, type of sampling strategy, and sample size (Creswell & Poth, 2017). The defined inclusion criteria limited the sample to nurses working within mental health care, but the criteria opened up for including nurses with different specializations, ages, genders, ethnicities, and lengths of experience, who worked in different clinical settings. The sampling strategy aimed at maximum variation on the site level by extending the request for study participation to any type of mental health care service in specialist and community mental health care.

Sampling strategy on the participant level was a combination of convenience and snowball sampling (Creswell & Poth, 2017). The planned sample sizes related to data collection method: 8-12 participants in participant observation, 10-12 participants for individual interviews, and 4-6 participants in a focus group interview. However, as the study progressed, the sample size was increased. The main reason for this was that more of the participants from specialist mental health care opted to participate before I had received confirmation about participation from nurses in community mental health care. Later, when more of the nurses from community mental health care wanted to take part in the study, I had already filled my originally planned sample size. Because I thought it was important to include nurses from different care settings (to increase chances of varied descriptions of the phenomena of interest), I chose to include more nurses from community mental health care and exceed the planned sample size.

3.2.1 Participant recruitment

In order to recruit participants, it is necessary to find individuals who can provide access to the research field (Creswell & Poth, 2017). The recruitment process began in the middle of May 2013 when I sent an email with a request for study participation to the regional head of the specialist mental health services. In the beginning of July 2013, I sent a participation request to the coordinator for community mental health care in a region of Mid-Norway. These organizational leaders forwarded my request to relevant psychiatric units and districts, who forwarded the request to their nurse employees (see Figure 1 and 2).

The letter accompanying the request informed about the study's background, purpose, and about me being a nurse and a criminologist. I received contact information for the first

participant in May 2013 and for the last participant in January 2014. At the end, 16 nurses had decided to participate.

Figure 1 Recruitment process in specialist mental health services

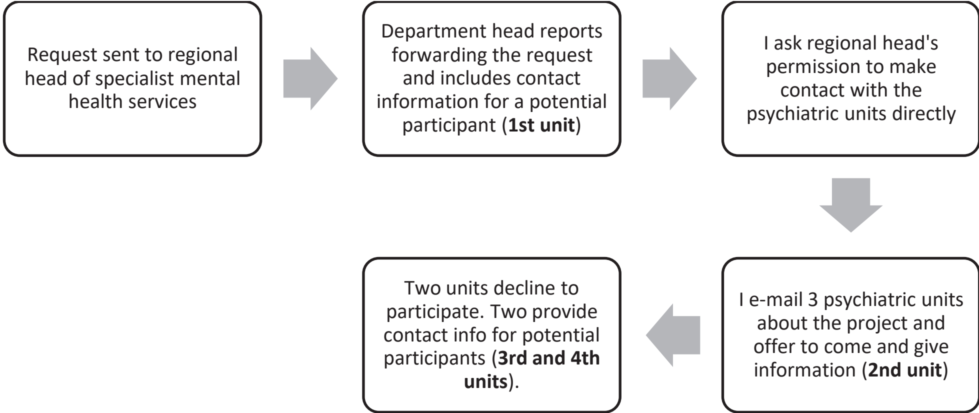
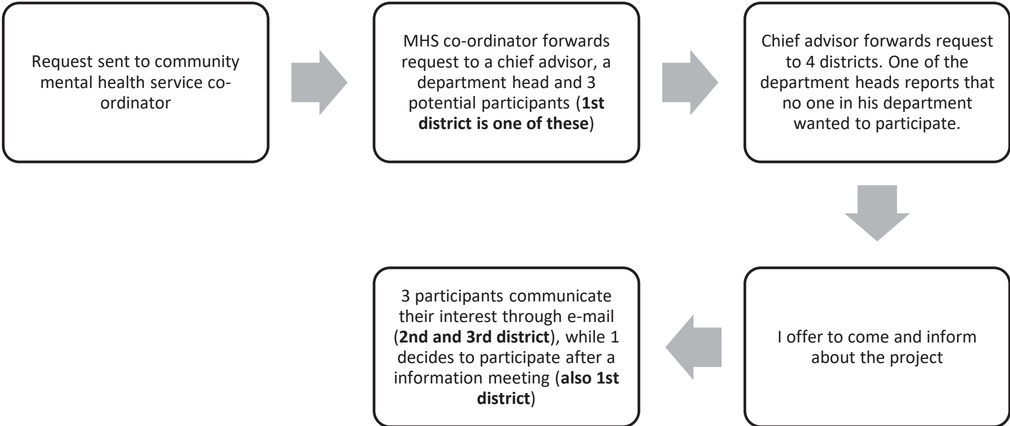


Figure 2 Recruitment process in community mental health services



After I did not get enough participants for the study in the 3 months after the formal request, I asked for and received permission to contact the different psychiatric units directly to present the study and encourage nurses to participate. Some participants communicated their interest in the study through their organizations' leaders, while others decided to participate after meeting with me directly in the field while I was following up on other participants or informing about the study (Table 2 Recruitment channels).

TABLE 2 RECRUITMENT CHANNELS

Recruitment channel	Participants (*N* = 16)
Indirectly through formal request	8
After meeting with researcher directly	8

I was confident that if I talked with the potential participants directly, it would increase chances of their participation in the study. In part, because I thought I would come across less threatening in person than as a distant researcher in a formal written request. I believed it was important that the participants and potential participants felt they knew me a little, enough to trust me with sharing their experiences through participating in the study.

Three of the nurses who decided to participate had met with me before the study when I was supervising nursing students in clinical studies in mental health care. McConnell-Henry, James, Chapman, and Francis (2010, p. 3) suggest that the stages of rapport building, which is fundamental in qualitative interviewing, are rapidly accelerated when the researcher and participant have a pre-existing relationship. As far as I know, eight participants had prior personal connections to me. These connections were mostly unknown to me until the participants pointed them out. Most had professional connections to my mother or brother, who also worked within mental health care, while some had personal connections to them or other members of my family. During the data collection process I also discovered that three of the participants had connections to friends of mine, but I got the impression that this connection was unknown to the participants, as they did not mention it in any way (neither did I).

Three nurses who were interested in the study, but who were unsure about participating, decided not to participate. Two changed their minds before data collection, while the third participated in one observation session before leaving the study. The nurses who did choose to participate had different reasons to do so. Some of the reasons they mentioned were interest in the topic, the importance of participating in research, and the possibility of learning something new. One nurse mentioned the risk of exposing oneself to critique as a possible downside to participating.

3.2.2 Participant characteristics

The 16 nurses who decided to participate were in the ages between 40 and 60. Three were male, while the rest was female (Table 3 Participant characteristics 1). The mean age was 52.

TABLE 3 PARTICIPANT CHARACTERISTICS 1 AGE AND GENDER

Age	*Female*	*Male*	*Total*
40-49	5	2	7
50-59	7	1	8
60-	1	0	1
Total	13	3	16

It had been five to 37 years since they became registered nurses. The mean number of years since becoming registered nurses was 21. Half of participants had over ten years of work experience in mental health care, while about a third (n = 5) had over 20 years' experience (Table 4 Participant characteristics 2 Professional experience).

TABLE 4 PARTICIPANT CHARACTERISTICS 2 PROFESSIONAL EXPERIENCE

# of years	*Registered nurse*	*Practice in mental health care**
0-9	2	7
10-19	5	4
20-29	5	4
30-	4	1

Note: * = years specified, unspecified years omitted

Almost all had specialized in mental health care (n = 15) and many had other specializations or courses in addition (n = 10). While many had worked in different nursing settings throughout their nursing career, four worked in community mental health care and 12 worked in specialist mental health care at the time of data collection.

Judging from the presence of different dialects among the participants, many originated from other regions of Norway and one had emigrated from another country, but I did not enquire or register data about their origin.

3.3 Data collection

The idea behind triangulating data sources in qualitative research is that it can be a means to gain a more precise or multifaceted description of the research phenomenon (Malterud, 2011), which made triangulation appropriate for the purpose of my study. Combination of different research methods can, as well, promote rigor and quality in qualitative research (Bourgeault et al., 2010). Different data sources can complement or correct each other, but source triangulation demands that the researcher immerses herself in each of the research methods, and this can be quite time consuming (Malterud, 2011).

I will describe each data collection method separately, but first I want to say something about the intentions behind the chosen sequence of methods. I planned that the results from participant observation would inform the development of the interview guide for the individual interviews. I intended to use the preliminary impressions and results from individual interviews to sort out what could be valuable to focus attention on in the focus groups.

Data collection started with the first participant observation in July 2013 and ended with three focus group interviews in March 2014. Sometimes the two sessions of participant observation and the two individual interviews took place in consecutive weeks, other times more than one

appointment was in the same week or spread over a longer period with weeks in between. I completed all participant observation and individual interviews before conducting the focus group interviews. Table 5 provides an overview of the empirical material.

TABLE 5 OVERVIEW: EMPIRICAL MATERIAL

Data source	*Period of data collection*	*Duration*	*Transcribed material**
Participant observation	July 2013 – March 2014	109.5 hours**	51.5 pages
Individual interviews	September 2013 – March 2014	38.2 hours	656 pages
Focus group interviews	March 2014	5.75 hours	104 pages
Total	9 months	153.45 hours	811.5 pages

Note: *Font size 12, single-spaced, **one session missing

3.3.1 Participant observation

According to Holloway and Galvin (2017, p. 107), many qualitative researchers believe that observation should complement or precede interviews. In my study, participant observation complemented the interview data on some topics (like what types of personal information the nurses shared with patients), but my experience was that observation was particularly important in developing the researcher-participant relationship.

A participant observation study consists of three key elements: accessing the location, building rapport with the participants, and spending enough time there to get the needed data (Guest, Namey, & Mitchell, 2013). In the study, I informed the different psychiatric units, districts, and nurses that participant observation was one of the data collection methods that they would take part in when they agreed to participate. I made appointments with the nurses directly, leaving it to them to set the date and time.

The first step in building rapport with the participants, the second key element in participant observation, was deciding how to present myself in the field. The researcher role is not necessarily the role that gives the easiest access and it can be necessary to have different roles in addition to the researcher role (Wadel, 1991). The night before the first observation appointment, I was preparing by reading up on researcher roles and I was contemplating on whether to introduce myself to the field as a researcher, PhD student, college university employee, or a nurse – or combinations of these. The first person I met when arriving at the psychiatric unit where I was meeting one of the participants, asked me if I was the daughter of L. A. V. (my mother's name), which I confirmed. Some minutes later, after having greeted some other people who worked there, one of them asked me if I was K. V. U.'s (my brother's name) sister and I confirmed. My planned role presentation was in this sense made superfluous by the roles that the field assigned me.

Accepting the given role is important in participant observation as it can make it easier for participants to relate and interact with the researcher (Fangen, 2010; Wadel, 1991). I did not make any efforts to contradict or reject the roles assigned to me by the participants. The personal connections were not particularly close – they meant that some participants knew *of* me, rather than *knew me*. I believe this distinction made it possible for them to see me as a researcher, even if they had some prior knowledge of me. Other participants gave me other roles, like referring to me as a doctoral student or a researcher. Roles can be negotiated during observations in the field, and it is possible to have more than one role at a time (Fangen, 2010; Wadel, 1991). On some occasions, a participant would leave me to attend to the patient they were assigned to, as if I were a colleague. The nurses' answers and actions suggested that they assigned me different roles. Some compared me to a student or to a colleague; others identified me as a researcher. My experiences from being a nurse in mental health care and a nurse educator led to role conflicts in certain situations where patients were involved. One such example was a situation I observed where a physician spoke to a young patient in a way that I perceived as manipulative and disinterested. The physician met the patient for the first time and used the patient's given name frequently, but without looking up at the patient. This conflicted combination of communication strategy (using the patient's name) and rejection (not looking at the patient) was, in my view, especially inappropriate in a conversation that touched upon dramatic (perhaps traumatic) events in the young patient's life. If I had been there as a nurse or teacher, I believe I would have at the very least, talked to the physician afterwards about being more respectful and sensitive toward patients. Nurse researchers may also experience difficulties in "delineating the researcher from the professional obligations associated with being a nurse" if participants talk about unprofessional health practices (McConnell-Henry et al., 2010, p. 4).

Participant observation is a research method were you participate not just as a researcher, but as a person as well (Fangen, 2010). It involves interaction and conversation with the research subjects, and ideally the researcher's presence feels so natural that the research participants feel comfortable even though the researcher's not exactly one of them (Fangen, 2010). In the individual interviews following participant observation, I asked most of the participants about how they experienced the participant observation. Their responses varied. Some compared having me following them around to having students following them. One nurse explained this by the fact that I was much younger than she was. One of the nurses worried that I did not think of her as a professional. She thought that I, as a researcher and a doctoral student, would expect to observe situations that were more like therapy and less like general patient

interaction. I ensured her that I did not think of her as unprofessional and added that the psychiatric unit where she worked was quite like the one where I used to work as a nurse.

The third key element in participant observation is being in the field for a long enough time that enough data is collected. What enough time is, depends on the scope of the research project (Guest et al., 2013). I observed most participants on two occasions. One participant was observed only once due to cancelling of appointments close to planned interviews. Another participant was observed three times because her work assignment hindered observations of her interactions with patients on the first appointment. A couple of nurses admitted that they were acutely aware of my presence at first, but that it changed as time went on, and one nurse said that after a while she almost forgot I was there. Participants were concerned with whether the time I spent with them was useful, that I would get my money's worth, so to speak. Some suggested specific times or situations that they thought would be well suited for observation. Several nurses had arranged for me to accompany them in many and varied patient interactions. Other nurses were less attentive, and I could be left sitting and waiting for them while they were busy.

The situations I observed felt, for the most part, quite familiar. I have worked as a nurse in different psychiatric units, and the types of interventions and interactions that the participants included me in resembled my experiences from mental health nursing. Situations included for example spending time together with patients in common areas, having one-to-one conversations, and going for walks outside. As much of my experience as a nurse comes from working in a forensic psychiatric unit, I have been trained in identifying and handling warning signals of aggression. This includes how you act and place yourself inside the psychiatric unit, and during observation, I would notice how I almost unconscientiously avoided turning my back toward patients. Even though it had been six years, my body and mind was alert as if I was back at work in the forensic psychiatric unit.

It is not unusual that researchers from time to time during the research process forget observing (Fangen, 2010). The list of things possible to observe is varied, but limited by research objectives (Guest et al., 2013). In my study, observations were guided by the study's purpose, but limited to collecting data on types of personal information disclosed to patients. I tried to avoid writing field notes during the first observations, but it did not take long before I felt an urgent need to take some notes to ensure remembering important data. Obvious note taking can make research participants less relaxed and more self-conscious about being observed (Fangen, 2010). The solution I settled on was having a small notebook with me, where

I wrote short notes during the participant observation. I mentioned the notebook to the participants, explaining that I needed it to remember important observations and reflections, and that I was not necessarily commenting on the exact situation at the time of writing. I did not want the participants to feel surveilled and criticized, and hoped that this explanation would make the note writing more inconspicuous. After finishing each observation, I would use the notes to write extended field notes upon arriving home.

Field notes should be descriptive and thorough, and it is important to avoid irrelevant data (Fangen, 2010). My field notes were quite selective, focusing almost exclusively, on the participants' sharing of personal information and the related context. Participant observation can open up for informal interviews (Fangen, 2010). While I conversed with the nurses during participant observation, I saw the contents of these talks as potential topics to return to in the individual interviews instead of an independent data source. In some situations, I interrupted a conversation by saying that we would talk about the subject during later interviews. In retrospect, I believe these conversations could have yielded important data, and I regret downplaying interviews during observation. Following the natural flow of conversation during observation can reduce the influence of researchers' preunderstandings (Fangen, 2010).

Observation times ranged from approximately two hours to nine and a half hours per participant, most lasting about three and a half hours per appointment. Observations were done during day (13) and evening (19) shifts. Participants from community mental health care only worked day shifts, while the others worked days and evenings. Evening shifts had more room for relevant nurse-patient interactions, so I prioritized observing during evening shifts in specialist mental health care.

3.3.2 Individual interviews

I developed the research questions that accompanied the study's purpose to elicit *descriptions* of the nurses' perceptions of and experiences with being professional, personal, and private. The research questions were open-ended in an effort to enable nurses to share freely their thoughts on the topics. The essence of the qualitative research interview is precisely this; to capture rich descriptions of the research participants' experiences, perceptions and meanings (Bourgeault et al., 2010; Brinkmann & Kvale, 2015; Kvale & Brinkmann, 2015).

The individual interviews were semistructured; following an interview guide with determined question areas (Bourgeault et al., 2010). The original interview guide contained 41 defined questions. I tested the questions in a preliminary interview with a colleague of mine who was a mental health nurse. The preliminary interview consisted of 2 sessions, the first lasting 1 hour

22 minutes, and the second lasting 1 hour 37 minutes. After this, I revised the interview guide. The revised interview guide contained ten topics for the participants' first interviews and eleven topics for the second interviews (Tables 6 and 7).

TABLE 6 INTERVIEW GUIDE FIRST INTERVIEW

Introduction	How did you experience being observed?
Background	Age Education Work experience
Questions (partly related to observation)	I.D. card Private clothes Using yourself as a tool Personal conversations in common areas Patients who you have become particularly close with
Outro	If you think of something in the meanwhile, before the second interview, please write it down and bring it to the interview

TABLE 7 INTERVIEW GUIDE SECOND INTERVIEW

Introduction	Anything come to mind since we last spoke. Something you want to add or explain.
Questions	Patients who you have become particularly close with Patients you do not want to work with Patients you know from other settings (family, friends) Situations where you felt you shared too much. Emotional reactions Contact with patients in off-hours (including accidental meetings) Gifts and services Social media What is the difference between personal and private? What does it mean to you to be professional as a nurse?

In addition, I adjusted interview guides to each individual interview to include specific topics that had emerged during participant observation and the first interview. A typical first interview would begin with questions regarding the participant's background, then proceed to questions based on issues that appeared during participant observation, and then touch upon the subject of becoming especially close to some particular patients. A typical second interview would begin with me asking if something special had come to mind since the first interview. Then the interview would continue with questions about relationships with patients (sometimes delving deeper into stories that the participant presented in the first interview), and then some talk about social media use and gifts. The last part of the individual interviews was concerned with digging into the concepts of being professional, personal and private. The individual interviews were in part conceptual interviews by the way they explored the concepts of being professional, personal and private, but they were also in part narrative interviews by opening up for stories related to these concepts (Kvale & Brinkmann, 2015).

I conducted all, but one, individual interviews at the participant's place of work. One interview took place at my office at the local university college per the participant's request. The participants had arranged for a suitable room (like offices or therapy rooms) where the interviews could take place. Sometimes there were interruptions during the interviews, like colleagues entering the room, but most of the time the interviews were uninterrupted. I had informed participants that each individual interview would last about one hour. Although I tried to keep within this frame, five interviews lasted for more than one hour and half. On most of these occasions, I asked if it was okay for the participant to exceed the agreed upon time. The shortest interview lasted 46 minutes, while the longest lasted one hour and 47 minutes.

The individual interviews felt different to me as an interviewer. Sometimes I would make an effort to make the interview feel comfortable if the participant expressed unease about being interviewed. The ability to make a participant feel comfortable and safe in disclosing is an important communication skill in qualitative interviews (Bourgeault et al., 2010). Other times I had to make an effort to adjust the tempo of the conversation to the participant's tempo. My impressions of the participants varied. Some interviews, gave me the impression that it was important to participants to portray themselves as well informed. Interviews have this in common with everyday social interactions in which "persons strive to present themselves in a favorable light" (M. Collins, Shattell, & Thomas, 2005, p. 189). In other interviews, I was surprised that participants did not have any answers other than "I do not know" to several questions. On some occasions, I sensed that participants felt questions implied critique. It is not unusual that participants may experience "considerable apprehension about the researcher's evaluation of them" – especially if the research involves "disclosures of unethical, immoral, or illegal acts" (M. Collins et al., 2005, pp. 190-191). Nursing research often explore acts that can cause harm to patients or other people, like the study of professional boundaries. I experienced some participants as inquisitive about my opinions, while others seemed to want to talk about other issues than the ones I brought to the table. Every now and then, I would become very self-conscious because my body language mirrored the participants or because some personal connection suddenly became clear from what the participant said. Being self-conscious drew my attention inwards and would sometimes make me lose my concentration. If it led to a halt in the interview, I would admit to the participant that I had lost my focus for a moment and we would get the interview going again together.

The relationship between the interviewer, the interviewee and the data in qualitative interviews is considered to be interactive (Bourgeault et al., 2010). Data are not seen as

discovered, but as produced – a product of the interaction between the interviewer and the interviewee (Bourgeault et al., 2010). The interviewer is not a blank screen, but takes part in co-constructing meaning (Holloway & Galvin, 2017, p. 98). The following excerpt from one of the interviews, Table 8 Interview excerpt, shows how I, as the interviewer, might have influenced the nurse's story:

TABLE 8 INTERVIEW EXCERPT

Nurse	Being allowed to say that you have become fond of the patient is something else. Yes and that it is acknowledged in a way, like you are allowed to say it. Then we are back to what I was talking about last time, that we are all human beings. You cannot have these walls between being a professional and being a human being. So I think it has been wonderful to get to say; yes, I do care about this girl or woman.
Interviewer	Do you think that acknowledgement should be given by colleagues, or...?
Nurse	Well, yes of course. Perhaps through supervision. That it comes there, from colleagues, that it is understood.

In the interview, my question about colleagues leads the nurse to reflect on the colleagues' relation to her wanting acknowledgement for caring for patients as fellow human beings. "The research interview is not a dominance-free dialogue between equal partners," states Kvale (2002, p. 12); "the interviewer's research project and knowledge interest rules the conversation." Researchers can empower participants by "listening to their perspective and giving voice to their concerns" (Holloway & Galvin, 2017, p. 98). Researchers are, however, not the participants' spokesperson. Researchers must adhere to the ethical and methodological rules of scientific inquiry and maintain their integrity and independence (Kvale & Brinkmann, 2015, p. 108).

3.3.3 Focus group interviews

The intention of the focus group interviews in the study was to delve deeper into some of the topics from the individual interviews. The purpose of focus groups is to get a better understanding of participants feelings or thoughts about an issue (Krueger & Casey, 2015). The focus group interviews provided an opportunity to look deeper into the nurses' experiences with professional boundaries. A benefit of group interviews is that "the members of the group generate new questions and answers" (Holloway & Galvin, 2017, p. 127). Other participants can comment, complement and challenge what a participant shares about her experiences, which can open up for new understandings of the research phenomenon. Focus group interviews are not aimed at creating consensus, but at discussing different perspectives on the matter at hand

(Kvale & Brinkmann, 2015). The focus group is considered a more natural environment than an individual interview, because participants are influencing and influenced by other participants (Krueger & Casey, 2015).

An important part of planning focus groups is to consider the size and composition of the groups (Krueger & Casey, 2015). Group size recommendations and practices vary. Some conduct focus groups with as few as three participants, other with 12 participants (Malterud, 2012). Group size considerations are a combination of both practical and substantive considerations (Morgan, 1997). In the study, all 16 participants had agreed to participate in focus group interviews. Two groups with eight participants each could have become disadvantageous, considering that I expected participants to share their opinions willingly. The decision fell on having three groups: two groups with five participants and one group with six participants. Because each participating psychiatric unit from specialist mental health care was represented with at least three participants, it was impossible to avoid close colleagues appearing in the same focus group. Participants who are familiar with each other can find it easier to talk to one another, making discussions flow more easily in the focus group setting (Malterud, 2012). The downside can be that two participants' flowing discussion can make other participants take a back seat to the discussion.

Since the participants were homogenous with respects to their educational backgrounds (being registered nurses with specializations), I made an effort to compose groups that were heterogeneous with respect to the nursing setting by including participants from both different psychiatric units and community mental health care in each group. This was also something that some participants had enquired about – which I interpreted as a curiosity about how the nurses in other nursing settings thought about being professional, personal and private in nurse-patient relationships. Unfortunately, three participants were unable to attend the focus group interviews. The final number of participants in the groups became three, five and five. Luckily, even the smallest focus group did not struggle with conversation flow.

Impressions from the individual interviews suggested that sharing personal information about the nurses' romantic relationships (their partners and significant others) was something that challenged the nurses' professional boundaries. Based on these impressions, a vignette was developed with the purpose of exploring the nurses' perceptions of professional boundaries – which is in tune with the aim of qualitative vignette interviewing (Hughes & Huby, 2002; Jenkins, Bloor, Fischer, Berney, & Neale, 2010). A preliminary version of the vignette was presented during a lecture I gave at a seminar (February 2014) for a group of employees in the

specialist mental health care services. The final vignette contained a hypothetical scenario that unfolded through four stages. This type of vignette is called a developmental vignette (Jenkins et al., 2010).

The scenario that the vignette introduced was this: A patient needs help after a difficult relationship breakup, the nurse talks with the patient who tells about despair following the relationship breakup, and the nurse has previous experience with relationship breakups. As a moderator in the focus group, I would then ask the participants about their assessment of what personal information the nurse in the scenario could or should share. Along with participants being asked what they would do, being asked about a third person's response is typical in studies utilizing vignettes (Hughes, 1998). The third person angle makes the discussion less personal, which can be beneficial when discussing sensitive subjects (Bradbury-Jones, Taylor, & Herber, 2014; Hughes, 1998). Vignettes do not predict the participants actions in real life situations, but can provide insight into participants elaborate interpretations of the scenario (Jenkins et al., 2010). Such interpretations can indicate the participants' attitudes towards and opinions on the subject matter. In addition, vignettes can prompt participants' sharing their own personal experiences (Hughes, 1998).

The participants would reflect upon the scenario together, and I introduced the next stages in the vignette if the conversation dried out or changed topic, or if the participants' discussion touched upon the topics of later stages. The three stages that followed the introductory scenario and stage was: If and how much the nurse can share about own experiences when; a) the patient and the nurse know each other well, b) the patient is diagnosed with emotionally unstable personality disorder, and c) the conversation takes place in the patient's home. The focus of the different stages was based on the interpretation of participant observation and individual interviews. The interpretations suggested that the nurse-patient relationship (stage a), the patient (stage b), and the context (stage c) affected nurses' self-disclosure. Previous research findings is one type of source that vignettes can be generated from, while collaborations with other professionals and real-life case histories are other sources (Hughes, 1998). By developing the vignette on the basis of interpretations of previously collected data, the vignette presented a plausible scenario – which is likely to produce more rich data than implausible ones (Jenkins et al., 2010; Ulrich & Ratcliffe, 2007). By keeping the descriptions of the stages short (a simple sentence), it was possible to trigger *it depends* responses from the participants – which is a way to explore factors that influence the assessment of the scenario in the vignette (Hughes, 1998).

I scheduled the three focus group interviews in one week at 2 PM, 10 AM and 2 PM, whereas the last two took place on the same day. I informed the participants that the focus group would last two hours, and that I would serve sandwiches and beverages half way through. Sharing a meal is considered a good way to promote communication within a group (Krueger & Casey, 2015).

Moderating focus groups can be a challenge. A successful moderator inspires a balanced discussion where every participant contributes with relevant and concrete stories that shed light on the research question (Malterud, 2012). Summarizing the number of replies for each participant is one way to illustrate the level of participation in the group discussion. The participants who had fewest replies, had about 40 – 50 replies during the two hour interview. The participants who had the most, had about 120 - 190 replies. The focus group with only three participants was naturally a little bit different and each participant had over 120 replies. One of the groups had two dominant talkers who were both active in talking with each other and engaging in dialogues with the other participants in the group. Sometimes I would moderate the conversation by directing follow-up questions to other participants verbally or by looking at other participants, which is one of several strategies that can be employed to engage more shy and reflective participants (Krueger & Casey, 2015). In another group, one participant simply had more to say about the topic without dominating the discussion in the group.

An assistant moderator helped me with certain tasks during the focus group interviews. While I moderated the discussion, the assistant moderator asked additional questions near the end and had a debriefing session with me after the focus group interview – which is some of the tasks usually assigned to assistant moderators (Krueger & Casey, 2015). The focus groups were audio taped digitally and transcribed verbatim. Transcription also indicated who said what, based on my recognition of the participants' voices.

3.4 Transcription

In my mind, I envision transcription like a bridge between the phenomenon, the raw data and the analysis. This is why it was important to me to do transcription myself, and it is why I wanted to write about transcription in this chapter between the chapters on data collection and data analysis. Transcription is what makes possible the analysis of the spoken word, and, at the same time, transcription *is* analysis. Transcription is a bridge that is anchored in the research phenomenon and that carries meaning across in analysis. Interpretations are already forming when the researcher makes decisions about what and how to transcribe.

A number of decisions are made when transcribing interviews (Bourgeault et al., 2010). The differences between spoken language and written texts make the construction of a transcript an interpretative process by demanding that the person transcribing make these decisions (Kvale & Brinkmann, 2015). Transcription techniques vary from naturalistic (every speech act is described) to denaturalistic (reads like standard text) (Bourgeault et al., 2010). Decisions about transcription styles depend on the nature of the research questions and type of analysis (Bourgeault et al., 2010; Kvale & Brinkmann, 2015). In light of the study's purpose and research questions, I chose a denaturalistic transcription technique in order to provide a written account of the interviews that was easy to read. By choosing this transcription technique, I wanted to center the attention on the stories that the participants shared. I limited inclusion of speech act descriptions that is more relevant to other types of analysis, e.g. conversation analysis. The participants in the study had different dialects, which I have translated into *bokmål* (literally "Book Language"). One of the participants was a non-native speaker, and I have added some words to make sentences more meaningful.

Remembering social and emotional aspects of the interview during the transcription contributes to the analysis of meaning in the data material (Kvale & Brinkmann, 2015). I made notes of some preliminary impressions and interpretations during transcription. Notes contained for example the impression that it was important for the nurses that patients perceived them as fallible, as opposed to perfect or successful. Some of the issues that I made notes of, turned out to be essential, like how the nurses adjusted their approach to different patients and how the nurses seemed to place being professional diametrical to being personal, while at the same time seeing being human as fundamental to being a professional nurse.

3.5 Data analysis

Analysis in papers 1 and 3 was based on systematic text condensation (Malterud, 2001, 2011). Systematic text condensation is an analytic process in four steps that Giorgi described and Malterud (2001) modified. It can be helpful to follow a guide to analysis as a novice researcher, and systematic text condensation provides a step-by-step guide. The first step is to get a total impression and identify preliminary themes, the second step is to code meaning units, the third step is abstracting and condensing the contents of individual meaning units, and the fourth step is to sum up their importance (Malterud, 2001, 2011). An important part of systematic text condensation is to validate findings by recontextualizing the findings in light of the data material as a whole, and this part of the analytic process proved to be important to the validity of the results in papers 1 and 3. Recontextualization led us, my co-authors and I, to

revise themes in both papers, and it helped with developing themes that contributed to answering the research questions of each paper.

During analysis, I struggled with finding a balance between a systematic analytic approach and the appropriate level of interpretation. Fangen (2010, pp. 208-213) describes how first level analysis is different from second level analysis. On the first level, analysis is descriptive and interpretations are close to the participants' own actions and words. More than once I experienced that if I worked very systematically through an analytic process, I would feel that the results became too descriptive and left little room for interpretations. Meanings that I sensed were within the data material, remained uncovered. This reminds me of what Holloway and Galvin (2017, p. 316) identifies as "an essential tension between the focus on method and creativity." Fortunately, my supervisors assured me that creativity had its rightful place in analysis and encouraged me to use an eclectic approach; *bricolage* – an approach that involves moving freely between different analytic techniques and concepts (Kvale & Brinkmann, 2015, p. 263).

The analytic work I did with the concepts *professional*, *personal,* and *private* (Paper 3) provides an example. I used NVivo 10 (QSR International, 2012) to code and organize codes in themes related to the research question about how the nurses define being professional, personal, and private. In the beginning, I identified several themes and subthemes that were very specific and descriptive. Later, I used NVivo 11 (QSR International, 2015) to identify all the text relevant to the concepts. I printed, read and analyzed the dataset again. In addition, I coded data by using the comments tool in Microsoft Word 2013, and I printed out data sets and coded by hand (comments, notes and color-coding). I returned to this dataset many times during analysis to make sure that the themes I developed stood their ground in light of the dataset as a whole. The movement between parts of the data material and the data material as a whole is an example of *the hermeneutic circle*. "Understanding is achieved by our interpreting within a circular process, in which we move from the individual parts to the whole through the hermeneutic circle," write Debesay et al. (2008, p. 58). Because one constantly acquires new knowledge, the circular movement does not bring one back to the same place, but rather to new knowledge in a spiraling movement (Debesay et al., 2008). Researchers within the hermeneutic tradition believe that a spiraling movement between the text as a whole and its individual parts contribute to reaching better and deeper understanding of the meaning (Kvale & Brinkmann, 2015, p. 237). The discussions my co-authors and I had throughout the analytic process were very important. A point made by hermeneutics is that texts are "always open to multiple interpretations because researchers or reflective persons are involved in their own

relationship with the world and others" (Holloway & Galvin, 2017, p. 226). Because of who we are, our position in the world, we interpret things differently. Our "*prejudices* or *preunderstanding* are necessary conditions for our understanding of the present," note Debesay et al. (2008, p. 58). Discussions about the study helped me further challenge my understandings and helped with delving deeper into the data material.

During the study, I tried out different types of qualitative analysis, e.g. systematic text condensation, narrative analysis and thematic analysis. Analysis in paper 2 was based on thematic analysis (Braun & Clarke, 2006). Thematic analysis is suitable for analyzing different types of data and can be used for both small and large datasets in order to answer a variety of research questions (Clarke & Braun, 2014). The versatility of thematic analysis made it an appropriate strategy for analyzing data materials stemming from different types of interviews (individual and focus group interviews). In addition, thematic analysis suited the research questions that my co-authors and I addressed in paper 2. Thematic analysis consist of five phases: becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, and defining and naming themes (Braun & Clarke, 2006).

The struggle with finding meaningful coding strategies and an appropriate degree of interpretation led me to repeated readings of the data material and selected data sets. The readings gave me an intimate knowledge of the data that benefitted the analytic process, especially when preliminary results conflicted my knowledge and intuitions about the data material. Such conflicts made me reconsider the preliminary results and work my way deeper into the data. Every time I started working on drafts for papers, I reread the complete data material. Sometimes I would read the complete data material many times and I wrote notes alongside every reading of the data material as a whole. There were different types of notes. Some were brief comments and questions, while others were more comprehensive, like written portraits of the participants. The notes were important in identifying topics that I would explore further depending on relevance to the study's purpose and research questions. One of the times I was preparing for a meeting with supervisors, I wrote a list of topics that had made an impression during a reading of the data material as a whole. Some examples of these topics are provided in Table 9 Preliminary themes.

TABLE 9 PRELIMINARY THEMES

Theme title	*Theme notes*
"The special patients"	Some patients have extended contact with the staff/professionals. Examples include two patients where the psychiatric unit or professionals engage in more contact than they usually do.
"Blurred boundaries"	When relationships go too far. One nurse's example of a dual relationship. Another nurse's example of sharing intimate personal information. Difficulties with terminating nurse-patient relationships. Patients who become dependent on the nurses.
"We are all different"	Differences between colleagues. Several nurses comment that they and their colleagues say and do things differently, that they have different opinions on where boundaries should be set.

I have read the data material as a whole with specific research questions in mind, but also without particular angles. Just wondering what the data material had to offer, which insights that might be there, maybe insights that I had not thought about asking about, but that still found its way into the data material. Perhaps there were stories that the nurses wanted to tell, stories that were important to them, no matter the questions I had prepared. One such story was about how suicidality and self-harm could challenge the nurses' professional boundaries, and how this seemed related to their perception of responsibility – the connection suggested by their emphasis on feeling burdened by being the nurse in charge.

While analyzing the data material with one research question in mind, I would also get ideas and reflect on other aspects of the study. The analytic process was not clean cut. Rather it was like a tree: the main subject being the trunk, and the different themes and codes being roots, branches and twigs, touching and infiltrating other tree's above and underground. Sometimes my line of thinking would follow a branch and then leap over to one on the next tree.

3.6 Researcher's position

In qualitative research, the researcher herself is the main research tool, and therefore it is important to make explicit the stance of the researcher (Holloway & Galvin, 2017, p. 4). "Interpretation and understanding is always affected by the subject's presuppositions and situatedness," notes Pedersen (2010, p. 326), and this is one of the widely accepted core insights from Gadamer's philosophical hermeneutics. An account of the researcher's position is part of the reflexivity that is highly valued in qualitative research. According to Berger (2015), the researcher's position impacts the research in three major ways. First, it impacts access to the field. Secondly, it influences the researcher-participant relationship. Thirdly, it affects how the

researcher interprets the information gathered, and thus shapes research findings and conclusions. In the following sections, I will account for some of the ways that my position might have impacted my study.

Researcher's positioning includes conveying the researcher's background, how it informs her interpretations in a study and what the researcher has to gain from the study (Creswell & Poth, 2017, p. 44). Positioning is how the researcher situates herself within the study by reflecting her history, culture and personal experiences (Creswell & Poth, 2017, p. 49). "It is necessary to describe preconditions which are considered to be of relevance to the researcher's interpretations", state Debesay et al. (2008, p. 64). It can be difficult to determine which experiences are most relevant, but a complete biography is unnecessary.

As a white educated woman, I share some significant characteristics with the participants in the study. Although I am younger than they are, I too have practiced nursing in different settings in mental health care. While I have an education in criminology in addition to nursing, I am not specialized in mental health care unlike most of the participants. My nursing experience is mostly from forensic psychiatry, which can be different from other mental health nursing settings in some important aspects. The patients I have met while working in forensic psychiatry have been severely mentally ill. Although nurses can come across similar patients in other settings than forensic psychiatry, the treatment milieu is especially adapted toward handling challenging situations like patients' aggression and violence in forensic psychiatric units. This is relevant to my position because the treatment milieu at the forensic psychiatric unit might have affected the types of relationships that seemed therapeutically possible for my colleagues and me. Maybe it is easier to transgress professional boundaries in nurse-patient relationships where nurses and patients feel and are more similar to each other.

Because I am a nurse, the participants were my peers in some respects. When researchers observe and interview their peers, "a more reciprocal relationship exists which make it easier for participants to become equal partners in the research enterprise" (Holloway & Galvin, 2017, p. 62). The participants' understanding of my role, whether they saw me as a peer or not, came across in comments they made during observation and interviews. Some would say or do things that implied they viewed me as a colleague, like the nurse who left me alone with a patient who was under continual observation. Other participants referred to me as a researcher or as a doctoral student. My background as a nurse educator is also part of my position in relation to the research field and the participants in the study. Some participants had met me as a nurse educator prior to the study. Nurse educators are in a position of power

relative to the nurses who supervise the students in clinical studies because nurse educators have the final say in decisions regarding students. The different roles I had in relation to the participants might have influenced what and how they shared their experiences with professional boundaries.

Information about my background was part of the written information that the participants received initially in the study. It included that I am a nurse, a criminologist and a doctoral student. In addition, it mentioned that Molde University College was my employer and that I was a student at the PhD program at the Centre for medical ethics (University of Oslo). I complemented this information when I met with participants, where I would talk briefly about my experiences from mental health care and how it had inspired the study.

Preconceptions are part of the researcher's position, and they influence how the researcher collects and interprets data. Researchers who research their peers may risk imposing "a framework which is based on their *assumption* of shared perceptions, and this this does not allow participants to develop their own ideas" (Holloway & Galvin, 2017, p. 62). Preconceptions include experiences, hypothesis, professional perspectives, and the theoretical framework that researchers bring into a research project (Malterud, 2011, p. 40). "Researchers must be open-minded," encourage Holloway and Galvin (2017), but "they cannot help having some 'hunches' about what they may find, especially if they are familiar with the setting and some literature on the topic." Preconceptions are reflected in the questions asked and the answers expected (Malterud, 1993, p. 202).

Initially, I imagined that being professional in mental health nursing revolved around professional knowledge and professional attitudes. I expected that the nurses would relate theoretical knowledge and ethical principles to their professional practice, and I expected that they would emphasize the patients' needs. I thought the nurses would say that being personal was connected closely to being professional because what you are like as a person influences what you are like as a professional. In addition, I expected that they would claim professional boundaries were necessary to avoid burnout. I imagined that the nurses would separate being private from being personal and professional. I envisioned that being private referred to something that was more sensitive than personal – that being private was more personal than being personal.

I used the original interview guide to document some of my own preconceptions. The example in Table 10 Preconceptions shows how I expected the nurses to answer one of the questions and how I would have answered the question myself.

TABLE 10 PRECONCEPTIONS

Interview question	Tell me about a time when you experienced having a particularly good relationship with a patient?
Expected answer	The nurse will talk about a patient they felt they had a good connection with, whom they liked, a patient that had some character traits or characteristics that appealed to the nurse. It could be a patient who was especially challenging, but who they succeeded in establishing a relationship with, a relationship that gave access to helping the patient. It can be a patient who charmed the nurse, or whom they felt they had something in common with. It could be a patient they strongly cared for, like caring for a child. A patient whom they have had contact with for a long time, that would be patients who have severe mental illnesses and greater challenges. Patients who they sympathized with, for example because of the patient's history, childhood and such. It could be a patient for whom the nurse became a favorite, a patient who let the nurse help, but who refused others' help. A patient who others had difficulties liking, but with whom the nurse had an alliance.
My answer	A patient who had a developmental disorder, who acted out aggressively, and violently. The patient was selective about who he wanted to cooperate with, and I was one of those he would let help him with different issues. The patient and I arrived at the forensic psychiatric unit at about the same time and stayed the seven years I worked there.

My early understanding of the concepts professional, personal, and private put the concepts in a continuum – a sequence where the different elements were professional at one end, personal in the middle and private at the other end. I based the continuum on experiences from working in mental health care as a nurse, where I saw myself and colleagues being professional, personal, and private to different degrees – like placing ourselves at different points in the continuum. Personally, I had contemplated the approaches of relatives who worked in health care and the approaches of professionals I had met as a patient. Moreover, I thought being private was unprofessional and I questioned (at least in my mind) professionals' decisions to involve patients in their private life through off-hours visits and so on.

3.7 Ethical considerations

In February 2013, I sent an application with a description of the study to the regional ethics committee. In March 2013 they concluded that the study fell outside the scope of the Norwegian Health Research Act (Helse- og omsorgsdepartementet, 2008) and could be undertaken without the regional ethics committee's approval. In April 2013, I registered the

study with the Norwegian Social Science Data Services (NSSDS) (project number 34079). In their response May 25 2013, the NSSDS determined that the study's processing of personal data required notifying the NSSDS. At the same time, the NSSDS concluded that the study's processing of personal data, provided in the notification form, met the demands stipulated in the Personal Data Act.

Ethical issues arise at different times during the research process, including prior to conducting the study, at the beginning of conducting the study, while collecting, analyzing and reporting data, and at publishing (Creswell & Poth, 2017). At the beginning of conducting the study, I made sure to inform participants about the study and its potential burdens and benefits. Although risks, burdens and benefits might be more obvious in research involving interventions and vulnerable patients, it is important to make sure all consent to participate in research is informed and voluntary (World Medical Association, 2018). Benefits related to participating in the study could be the opportunity to share thoughts and experiences with issues that are a substantial part of nursing in mental health care. It could contribute to develop the participants' reflections regarding their own practice, perhaps making them more professionally founded. The study could also benefit the profession itself by advancing the knowledge about what it means to be professional, personal, and private in mental health care – which could be relevant to other professions as well. Participating in the study could become a burden if the participants felt I questioned their professionalism or if they felt threatened by discussions or disagreements in focus group interviews. Participants' reactions culd also involve how they felt they came across in the study, perhaps especially if they had shared their experiences with crossing boundaries in blameworthy ways.

While collecting data it is important to build trust through avoiding deceiving participants about the purpose and use of data (Creswell & Poth, 2017). Participants and third parties, like patients and colleagues, were informed about the reason for my presence during participant observation (often by the participants, and by me if the participants did not disclose the purpose of my presence). Privacy and confidentiality are important ethical issues which must be protected during data collection (World Medical Association, 2018). Privacy and confidentiality are "tricky ethical matters" that cannot be handled exclusively by universal standards like signing a consent form (Mattingly, 2005). In order to protect the participants' privacy, I left out identifying information like names and places in notes and while transcribing. Focus groups present an unique ethical issue because what the participants share with the researcher, is also shared with the other participants in the group (Morgan, 1997). I addressed this in the focus group interviews by asking the participants to keep the content of

the interview private, which the participants agreed to. The digital audio recordings and research documents were stored securely (password protected).

Data analysis is subject to ethical issues which can be addressed by reporting multiple perspectives and contrary findings, and using fictitious names on participants (Creswell & Poth, 2017). When reporting data, several different ethical issues need to be addressed. These issues include amongst others, falsifying authorship and findings (Creswell & Poth, 2017). The Vancouver Convention has set requirements for publication of scientific articles that medical journals use (International Committee of Medical Journal Editors, 2018; The Norwegian National Research Ethics Committees, 2015). My co-authors and I met the authorship criteria defined by the Vancouver Convention for each of the papers that we have written together. Protecting confidentiality is another ethical issue related to reporting data, and there are different strategies to doing this. There are four main strategies to avoid reporting identifiable case material: altering or limiting specific characteristics, adding extraneous material, or using composites (American Psychological Association, 2010). In reporting from the study, these strategies include third parties (like patients and colleagues), making the participants' stories even less identifiable. Sometimes it is a good option to obtain written consent from the research participant (American Psychological Association, 2010). This was the case in paper 2 where I obtained an additional consent to publish a participant's story about her experience with a dual relationship. The additional consent came in addition to omitting and changing nonessential identifying details.

After publishing research reports, a good way to be sensitive to ethical issues is to share reports (Creswell & Poth, 2017). In the study, I regularly updated the participants on the study's developments, such as publications. I had offered to keep the participants updated after finishing the last interviews, and all participants were interested in receiving updates. In addition, I offered to present the published papers to the psychiatric units and community mental health care districts that were involved in the study. Some accepted the offer and invited me to give presentations at seminars (February and March 2018). Presentations based on the study have also been given at a PhD course at Molde University College (March 2018), a meeting with the Council for Nursing Ethics (May 2018) and at a seminar for the Nordic Councils for Nursing Ethics (September 2018).

4 Results

The study's purpose was to explore nurses' perceptions of and experiences with being professional, personal, and private in nurse-patient relationships in mental health care. The research questions that guided the study included professional boundaries in general and specific boundary issues. Paper 1 addresses what kind of personal information nurses disclose (research question 3) and what influences the nurses' disclosure decisions (research question 4). Paper 2 addresses nurses' contact with current and/or former patients outside work hours (research question 5). Paper 3 explores the nurses' descriptions of being professional, personal, and private, and how these terms relate to one another (research questions 1 and 2). A brief description of the papers follows.

4.1 Paper 1: Transforming nurse-patient relationships

The aim of paper 1 was to describe what and why nurses self-disclose to patients in mental health care. Analysis resulted in four themes addressing *what* nurses self-disclose, and one main theme and four subthemes addressing *why* nurses self-disclose.

The four themes that described *what* nurses self-disclose were: Immediate family, Interests and activities, Life experiences and Identity. These themes represent different types of personal information, and the participants usually disclosed all types. The nurses' reasons for disclosing personal information were related to wanting to change the dynamics of the nurse-patient relationship. The nurses expressed that they could affect the nurse-patient relationship, and make it more open, honest, close, reciprocal and equal by disclosing personal information. The four subthemes revealed that this change in the relationships was connected to different interactions that took place within the nurse-patient relationship. The first subtheme signaled that nurses and patients can struggle with similar issues, and that nurses find it purposeful to share this with patients. The second subtheme described how the nurses' life experiences provide insights that can be helpful to the patients. The third subtheme revealed that context play an important part in nurses' decisions about self-disclosure by pointing out how self-disclosure felt natural in certain situations. The fourth subtheme linked nurses' self-disclosure to patients' questions and how not answering sometimes was seen as disrespectful and unnecessary.

Paper 1 concluded that self-disclosure is common among nurses, and that there are a number of reasons for nurses' self-disclosures. Paper 1 was published in the Journal of Clinical Nursing (Unhjem, Vatne, & Hem, 2018).

4.2 Paper 2: Encountering ambivalence

The aim of paper 2 was to explore how nurses describe their contact with current/and or former patients outside of work hours. Analysis revealed that the nurses experienced ambivalence in three areas concerning their dual relationship with patients.

The first area of ambivalence had to do with the nurses' perceptions of the patients. The nurses' descriptions portrayed the patients as enjoyable and interesting people, while also being persons diagnosed with severe mental illness. The second area of ambivalence concerned how the nurses assessed the situation. At the same time as the nurses adhered to a rule about not engaging in dual relationships, they found good reasons to make exceptions to this rule for some extraordinary patients. The third area of ambivalence shed light on the nurses' experiences of receiving both support and criticism for their dual relationships from people in the surrounding context.

Paper 2 concluded that dual relationship decisions were complex and highly contextually dependent, and that education and guidelines might be inadequate in helping nurses define and maintain relationship boundaries. Paper 2 was published in Issues in Mental Health Nursing (Unhjem, Hem, & Vatne, 2018a).

4.3 Paper 3: The ethics of being professional and personal

The aim of paper 3 was to explore how nurses describe being professional, personal, and private, and how these terms relate to one another.

How nurses establish and maintain professional boundaries affect patient outcomes in mental health care. We explored professional boundaries through a multisite qualitative study with source triangulation. Sixteen nurses shared their views on being professional, personal and private. The concepts turned out to be deeply interconnected. Being professional represented a safe ground based on theoretical and experiential knowledge. Being personal seemed intrinsically linked to being professional, while being private was, for some, separate. We discuss this in light of a feminist ethic of care and suggest that boundary decisions are relational and contextual.

Paper 3 concluded that professional boundaries in nurse-patient relationships involve both professional and personal considerations. The relational and contextual nature of boundary decisions call for case-by-case considerations informed by legislation and professional codes of ethics. Paper 3 has been submitted for review in the journal Advances in Nursing Science (Unhjem, Hem, & Vatne, 2018b).

5 Discussion

The purpose of the study was to explore nurses' perceptions of and experiences with being professional, personal, and private in nurse-patient relationships in mental health care. Together, the papers' results demonstrated that nurses perceived being professional, personal, and private as interconnected. The nurses' personality and personal preferences played into their decisions regarding professional boundaries related to self-disclosure and dual relationships (Papers 1 and 2). The nurses' experiences pointed to a clinical reality where nurses made boundary decisions on a case-by-case basis because context and particular relationships had vital importance (Papers 1, 2 and 3). Since professional boundaries were contextual and relational, nurses had to rely on their own individual judgements (Paper 3).

These results bring up two issues that I want to discuss further. The first is the question of responsibility. The results suggest that nurses experience boundary decisions as dependent on their own individual assessment in particular cases. Does this mean that nurses bear the sole responsibility for professional boundaries? The second issue I want to discuss is the consequences of how professional boundaries are set. Appropriate professional boundaries, on one hand, seem to have the power to strengthen nurse-patient relationships and thus facilitate patients' recovery. Inappropriate professional boundaries, on the other hand, are ripe with predicaments. I will discuss the issue of responsibility first, before I move on to effects related to professional boundaries.

5.1 Professional boundaries – A personal responsibility?

The study revealed that the nurses felt each nurse must set her own individual boundaries based on personal preferences and the situation at hand (Paper 3). The nurses valued setting boundaries depending on the characteristics of specific nurse-patient relationships and particular situations (Papers 1, 2 and 3). In addition, they claimed each nurse's right to find her own way of setting boundaries (Paper 3).

Because Norwegian legislation refers to responsible conduct in general (chapter 2.2.2), nurses' codes of ethics do not mention professional boundaries specifically (chapter 2.2.3), and nursing textbooks address the issue briefly (Jones et al., 2016; Kristoffersen et al., 2011; Stuart, 2013), I will include the Norwegian Board of Health Supervision's (NBHS) assessments in disciplinary cases regarding professional boundaries (also mentioned in chapter 2.2.2) in the following discussion of boundary responsibility. The NBHS's assessments in disciplinary cases contrast and complement the individuality of professional boundaries that the nurses in the study experienced.

5.1.1 A division of responsibility

Professionals bear the full responsibility for establishing and maintaining appropriate boundaries, according to the NBHS (Statens helsetilsyn, 2014, 2016). The expression "with great power comes great responsibility" is relevant to understanding the relationship between nurses' roles and responsibility for professional boundaries. The expression and variants of it can be found in different sources dating back to the 1700's (O'Toole, 2018). At the core of the expression is the notion that power entails the responsibility to manage the power responsibly. For nurses and other professionals, the power that comes with their professional role obligates them to act responsibly. In other words, the professionals' monopoly on responsibility is founded on the professionals' role of power in therapeutic relationships.

Nurse-patient relationships are fundamentally asymmetric and one-sided, and nurses are ethically and legally obligated to respond to the patients' needs for help (Kristoffersen et al., 2011). Some nurses in the study talked about their experiences with feelings of responsibility, while others shed light on boundary responsibility through their descriptions of establishing and maintaining boundaries. The nurses took responsibility for attuning self-disclosures to the patients' current conditions and they were sensitive about self-disclosures' impact on the patients' feelings (Paper 1). The nurses acknowledged the patients' vulnerabilities and linked their professional boundaries to the patients' best interests. The primacy of patients' interests was also apparent in the nurses' decisions about dual relationships. Patients' best interests could be a reason to avoid, or in some particular instances enter, dual relationships (Paper 2). For some nurses, like the one in the study who had a dual relationship with a former patient who expressed suicidal thoughts, the relationship can feel like an overwhelming responsibility (Paper 2). Feelings of being responsible for the patients' well-being can make nurses unsure of their professional boundaries. Sometimes the feelings of responsibility and the uncertainty about what the patient might do to herself, made nurses cross boundaries (Paper 2). Dual relationships could increase the nurses' experiences of responsibility because the nurses had to handle suicide threats on their own (Paper 2).

Feelings of responsibility can increase when nurses face boundary decisions alone. Gutheil and Brodsky (2011, p. 285) write that experienced professionals practice and teach the maxim: "Never worry alone". In one disciplinary case from the NBHS, the nurse wished there had been more focus and guidance on relationships between patients and professionals (Statens helsetilsyn, 2016). The nurse had received a warning for having a dual relationship with a patient and expressed that it was difficult for her to set boundaries in the relationship with the patient. The support of colleagues or supervisors is essential to help deal with pressures like

boundary challenges (Gutheil & Brodsky, 2011). The NBHS states that it is a professional's responsibility to seek advice from colleagues or supervision when challenged by boundary issues such as dual relationships (Statens helsetilsyn, 2014, 2016). Colleagues can influence nurses' boundary decisions through their support and critique. "It is important to consult with colleagues who understand one's work," says Reamer (2012, p. 210). Even if colleagues understand the particular context that the professional boundaries exist within, opinions on where boundaries should be set can differ. One of the nurses in the study experienced that her colleagues disagreed with and criticized her decision to become involved in a dual relationship with a patient (Paper 2). The nurse's colleagues thought the patient used and manipulated her. Nurses' difficulties with balancing professional boundaries can be related to colleagues' attitudes, as well as the nurses' own vulnerability and contradictory aspects of professional ideals (Hem & Heggen, 2003). A study on the relationship between trust in work colleagues, impact of boundary violations, and burnout among staff within a forensic psychiatric service, found that professionals who reported a higher frequency of boundary violations were less trusting of their colleagues (H. Johnson et al., 2016). Nurses who work in psychiatric units depend on their colleagues for support and guidance. If colleagues fail to help prevent boundary violations, this can lessen trust between colleagues – which might make nurses more susceptible to seeking out alliances with patients and perhaps transgressing boundaries.

In some disciplinary cases where professionals have faced sanctions from the NBHS, the professionals have claimed dual relationships were initiated by the patient and/or mutual. The nurses in my study described the patient's role in boundary decisions in relation to dual relationships and self-disclosures. With regard to the latter, patients' enquiries for nurse self-disclosures influenced whether the nurses chose to share personal information, but not necessarily the amount or level of detail (Paper 1). Some patients are quite inquisitive, while others can be apprehensive about intruding on nurses' privacy. With regard to dual relationships, the patients influenced the nurses' boundary decisions through the qualities of their relationship with the nurses, for example if the relationship lasted a long time or the nurses and patients had much in common. Patients can inspire and inquire about dual relationships. Some nurses in the study engaged in dual relationships because they assessed that it was in the best interest of the patient, sometimes because they thought the patient would not receive enough help and support from the public mental health services (Paper 2). Other times, patients can invite nurses to continue their relationship through dual relationships, like the one patient who wanted a nurse in the study to become her support contact (Paper 2). While patients can suggest, want, or need nurses to enter dual relationships,

neither the NBHS nor courts of justice seem to place any responsibility for professional boundaries on the patient. They agree on the professionals' full responsibility in dual relationship cases.

Even if professionals are responsible for their own boundaries, employers are responsible for organizing the work in such a way that it prevents and reveals possible role confusions (Statens helsetilsyn, 2012a). Employers are responsible for getting an overview over areas where there are risks. The risk for boundary transgressions is considered increased in situations where treatment involves or presupposes that the patient and the professional share intimate, guilt-ridden, or shameful personal information in private sessions, especially if treatment spans over a period of time (Statens helsetilsyn, 2012a). Other factors that increase the risk of role confusion include situations where patients are particularly vulnerable (like having a mental illness or previous history of abuse), situations where there is a lot of physical touch, and situations where the professional spends a lot of time alone with the patient (Statens helsetilsyn, 2012a). The risk areas that the NBHS specifies coincide with significant characteristics of mental health nursing. One such characteristic is that patients are vulnerable due to their mental illness (Jones et al., 2016, p. 50). Moreover, mental health nurses have access to patients' intimate personal information. The primary nurse model, which is prevalent in mental health nursing (including specialist and community mental health care), facilitates close nurse-patient relationships where patients spend more time with their primary nurse than other nurses. Sometimes these relationships last many years, perhaps especially in community mental health care. Even if mental health nursing seems to be an area of increased risk of boundary transgressions, the nurses in the study gave few examples of employers' involvement in their boundary decisions. Some nurses in the study described how their supervisors contributed to organize the nurses' workloads so that they could spend as much time as possible with particular patients (Paper 2). The increased amount of time spent with particular patients seemed to have contributed to creating close nurse-patient relationships that later developed into dual relationships.

In the NBHS disciplinary case where a nurse had her license revoked after a 7.5-year dual relationship, the nurse was critical of how her employer handled the case (Statens helsetilsyn, 2014). When the nurse informed her employer about the dual relationship, the employer agreed to keep it secret. The employer was under the impression that it was a non-sexual dual relationship and did not see the need to do anything about it, except arranging for the nurse to have the least possible amount of contact with the patient while the patient was admitted to the unit. The employer had no tools for preventing dual relationships or routines for handling

them if they arose (Statens helsetilsyn, 2014). Some employers state that professional boundaries are an important subject in introductory courses, treatment team meetings, and counselling. The NBHS insists that employers are responsible for providing necessary training depending on the professionals' competency and the nature of their work tasks (Statens helsetilsyn, 2012a). On the subject of *role confusion* (a term that corresponds with the term *boundary transgressions*), the NBHS states that training should involve topics related to dual relationships, self-disclosure and balancing being professional, personal, and private. Topics include what it means to be personal and private when working with intimate relationships, the professional's responsibility for not developing private or sexual relationships with patients even if patients want to, avoiding all forms of verbal intimacy that may be interpreted as sexual, and the professional's responsibility to avoid developing private or sexual relationships with former patients (Statens helsetilsyn, 2012a).

While the NBHS points to important topics that can be helpful in guiding professionals' boundaries, the instructions can be hard to follow since the ethical codes of conduct and guidelines that complement legislation struggle to balance specificity with the need for context sensitivity. The legal term *responsible conduct*, which includes professional boundaries, depends on the professionals' qualifications, the character of their work, and the situation in general. Some questions come to mind. Given the contextual and relational character of boundary decisions, is it even possible to set a standard for professional boundaries in nurse-patient relationships? Although some absolutes might exist, like avoiding sexual relationships with current patients, most boundary issues are less clear-cut. Would detailed guidelines promote or prevent the therapeutic relationships that are essential to mental health nursing?

5.1.2 Standing alone together

From a legal viewpoint, nurses must take full responsibility for their boundary decisions. The NBHS presupposes that nurses are familiar with the dangers of privatizing a treatment relationship (Statens helsetilsyn, 2018b). This does not mean that nurses are better off left alone with their deliberations on professional boundaries. While nurses need to adjust professional boundaries to specific nurse-patient relationships, deliberations could benefit from incorporating professional knowledge, legislation, codes of ethics, and the support and supervision from colleagues and employers. The Norwegian Council for Nurse Ethics recommends discussing boundary issues regularly at the work place. Their experience is that such efforts are very useful (Dolonen, 2018). By standing together in boundary decisions, nurses, their colleagues, and employers could contribute to safer therapeutic relationships between nurses and patients in mental health care.

5.2 The power and predicaments of a personal approach

In this chapter, I will look closer at how a personal approach in nurse-patient relationships holds potential for better patient care. I will suggest that by being personal, nurses can relate genuinely to patients in mental health care and gain a position from where it is possible to facilitate growth and healing. In addition, I will consider some risks related to boundary transgressions that I believe are critical. Being personal speaks to nurses and patients' vulnerability, and as I will make clear, inappropriate boundaries can have detrimental consequences for both.

5.2.1 Closing the professional distance

Being professional represented a safe ground for the nurses in the study, but being personal was at the same time integral to being professional (Paper 3). Professional boundaries were partly associated with protection from emotional distress and risks of burnout (Paper 3). This is similar to what Carling (1975, p. 47) noticed; that some professionals used a particular interpretation of the term professionalism to avoid a human involvement that they felt they could not cope with. This resembles how nurses described a professional face as emotional protection (Cecil & Glass, 2015) and medical students described being a professional as "an antithesis to being humane" (Eikeland, Ørnes, Finset, & Pedersen, 2014, p. 3). Instead of seeing professionalism and humaneness as contradictory, Carling claimed that professionals were not professional enough, that they were not confident enough in their professionalism, and did not experience it as a basis for human insight (Carling, 1975, p. 49). Contrary to Carling's claim, the nurses in the study saw professionalism as a basis for insight into their relationships with patients. The nurses' descriptions of professionalism as a safe ground emphasized how professional and experiential knowledge could improve the nurses' approaches to the patients (Paper 3). The nurses' interpretations of being professional included professionalism as a stepping-stone for managing challenging relationships with the patients, and professionalism as taking a step back and creating distance to their own emotional reactions and the patients.

Imbalanced professional boundaries could threaten the professional distance that was necessary to provide care in the right way, according to the nurses in the study (Paper 3). Professional distance is an established concept within the medical professions. A study of medical students reflects this, reporting that the medical students understood "developing a certain emotional distance from the patient, and avoiding too much empathy" as being key to being professional (Eikeland et al., 2014, p. 3). Professional distance is "premised on the belief that a psycho-social separation will encourage rational scientific objectivity" (O'Leary et al., 2012, p. 137). In the objectivity-subjectivity dichotomy, objectivity is associated with distance,

while subjectivity is associated with being personal and emotional. Professional distance is something to be balanced with emotional involvement (Hagen, Knizek, & Hjelmeland, 2017) and is a continuous and dynamic process (Bernhardt, Nissen-Lie, Moltu, McLeod, & Råbu, 2018). "In a philosophical hermeneutic perspective, [...] human understanding is never completely objective or subjective", writes Pedersen (2010, p. 105).

Recent studies (Olsø, Almvik, & Norvoll, 2015; Smythe, Hennessy, Abbott, & Hughes, 2018) challenge the traditional view that professionals should maintain a distant professional role in mental health care. One of these studies questions whether "professionalism has robbed us of the very thing that makes relationships work" (Smythe et al., 2018, p. 293). Clear boundaries have been associated with quality therapeutic relationships in mental health nursing. However, "an overtly professional role can conflict relationship development" (Dziopa & Ahern, 2009, p. 7). This was also the view of some of the nurses in the study. They saw how colleagues, who they perceived as distant professionals, failed to establish close relationships with the patients (Paper 3). Patients can experience too professional nurses as unapproachable and difficult to connect with (Thomas, Shattell, & Martin, 2002). If patients understand relationship boundaries as rules, it can be detrimental to the helping relationship (Grant & Mandell, 2016). In a recent study, nurses voiced the importance of balancing professional distance with allowing oneself to "be human with people" and acknowledging there is a "difference between having a barrier that's a rigid wall and having a barrier that sort of sways with the wind a bit" (Gerace, Oster, O'Kane, Hayman, & Muir-Cochrane, 2018, pp. 98-99).

Patients have expressed that good or helpful helpers are those who go beyond usual professional conduct, who break or bend professional boundaries, for the sake of the patient (Borg & Kristiansen, 2004). Extra efforts, doing more than expected, was described by mental health service users as a vital component of helping relationships (Denhov & Topor, 2012). Breaking standardized routines and professional codes of conduct involves taking a stand on behalf of the patient against the system, according to Karlsson and Borg (2017). A nurse in my study admitted she disregarded referral procedures in order to continue her relationship with a patient (Paper 3). The nurse felt it was in the patient's best interest that they continued their relationship. Another study suggests that mental health support workers who go beyond what is usually considered professional practice "might trust and be trusted in ways that their professional colleagues are not able to achieve" (Smythe et al., 2018, p. 293). When professionals go beyond what was expected, patients can feel being chosen (Topor et al., 2006).

Traditional representations of professional boundaries have been criticized for reinforcing power imbalances and undervaluing the personal exchange required in therapeutic relationships (O'Leary et al., 2012). The nurses in the study expressed an understanding of being personal as essential to having professional nurse-patient relationships (Paper 3). Who the nurses were as persons, as human beings, permeated their professional approach to patients. Not being personal seemed not only impossible, but also undesirable. Colleagues who chose a distant professional role could come across as unfit to connect with patients in mental health care (Paper 3). Nurses, who managed to establish especially close relationships with patients, could receive praise from colleagues (Paper 2). The perceived benefits of being personal were evident in the nurses' experiences with self-disclosure. The nurses in the study saw self-disclosure as a valuable tool to make relationships with patients more open, honest, close, reciprocal, and equal (Paper 1). According to the nurses, self-disclosures had therapeutic value. Through disclosing personal information, the nurses felt they could help normalize patients' experiences and provide useful advice (Paper 1). Self-disclosures could also be a way to reduce the asymmetry in the nurse-patient relationship by leveling out the amount of information they had about each other (Paper 1).

The nurses in the study are not alone in championing the value of applying oneself personally in relationships with patients. The concept of being personal in nurse-patient relationships is paralleled by Martin Buber's writings about finding connection through *I and Thou*-relations (Buber, 2013), in Rogers' theory on conditions for personality change (Rogers, 1957, 1961), in Travelbee's portrayal of human-to-human relationships in nursing (Travelbee, 1971), and in Jourard's understanding of transparency as vital to health and personal development (Jourard, 1971). The common denominator in these theories is that helpful relationships depend upon the persons relating to one another as genuine human beings – as opposed to objectifying one another through roles and facades.

These theories find support in a growing body of empirical research. In my experience, there are varied descriptions of professionals' being personal, and the following are some examples: "A deeply humanistic style of working" is a characteristic of good helping relationships (De Boer & Coady, 2007, p. 38). Patients confirmed that doctors' exposed vulnerability through personal disclosure had potentially beneficial effects (Malterud & Hollnagel, 2005). Relating to clients in a person-to-person manner and going the extra mile is important in child welfare services (De Boer & Coady, 2007). Genuine and credible professionals contribute to working relationships, according to ambulatory team service users (Almvik et al., 2011). Mental health service users wanted professionals to come forward as persons and give of themselves instead

of being distanced professionals (Borg, 2009). Patients found “value and utility in the presence of providers who genuinely cared about them” in their recovery from psychosis (Davidson et al., 2005, p. 191). Human-to-human connectedness is the foundation of a trusting relationship (Smythe et al., 2018).

In several studies, helping relationships are compared to friendships, being friendly or acting as a friend (Berggren & Gunnarsson, 2010; Denhov & Topor, 2012; Dziopa & Ahern, 2009; Gardner, 2010; Hem & Heggen, 2003; Jackson & Stevenson, 1998, 2000; Müller & Poggenpoel, 1996; Olsø et al., 2015; Topor, Bøe, & Larsen, 2018). The association with friendship may serve as a convincing claim about the value of being personal in professional relationships. In my study, some of the nurses used the terms friend and friendship to describe their dual relationships. One nurse said she became friends with a former patient who was admitted to the psychiatric unit after a suicide attempt (Paper 2). Another nurse explained that when she became a friend to a former patient, she misinterpreted the professional role (Paper 2). The connections between professional relationships and friendships can be troublesome. Davis (2000, pp. 28-29) describes how the friendship ideal, despite its long history as an ideal and model for patient-physician relationships, is problematic due to some essential features of patient-physician relationships that are mostly absent from friendships.

According to Davis (2000, pp. 28-30), the professional relationship differs from friendship in four ways. First, there is the inequality of power resulting from the patient’s vulnerability and the professional’s knowledge and skill. Secondly, there is the professional’s obligations and responsibilities toward the patient that the patient does not have toward the professional. Thirdly, while friendships are freely chosen and relatively independent of social and institutional structures, the professional-patient relationship is enmeshed in such structures. Fourthly, professional relationships are oriented towards the achievement of an end, not towards a particular good or goods, as is the case with friendships. One of the nurses in the study believed that the patient she was having a dual relationship with, managed to separate the nurse’s roles as a friend and as a nurse depending on whether they met in or outside the nurse’s work hours (Paper 2). However, the different features of friendships versus professional relationships can make transitions between the two difficult, like in the case of the nurse who felt burdened by the demands from a patient with whom she had a dual relationship (Paper 2). As the relationship changed character, it became increasingly difficult to handle. Role conflicts can emerge, and “the greater the incompatibility of expectations is, the greater the role strain is for the individual in the roles,” writes Kitchener (1988, p. 218).

While friendship might be a problematic ideal, there is still something to be said for being personal in nurse-patient relationships. The study found that some of the nurses wanted to emphasize a shared humanity through sharing existential and everyday sentiments with the patients (Paper 1). The nurses in the study communicated clearly a view of nurse-patient relationships as human-to-human relationships (Paper 3). To feel and be treated like human beings, like persons, is important to patients (Shattell et al., 2006; Shattell, Starr, & Thomas, 2007; Topor & Ljungberg, 2016; Von Greiff, Skogens, & Topor, 2018). A human-to-human relationship is characterized by how "each participant in the relationship perceives and responds to the human-ness of the other" and it transcends "the barriers of title, position and status" (Travelbee, 1971, p. 124). The idea of a human-to-human relationship finds resonance in the concept *presence*.

Presence in nursing is defined as an interpersonal process characterized by "sensitivity, holism, intimacy, vulnerability and adaptation to unique circumstances" (Finfgeld-Connett, 2006, p. 708). These characteristics echo elements in the nurses' stories about self-disclosure (Paper 1) and dual relationships (Paper 2). The nurses in the study adapted self-disclosures to the uniqueness of each relationship; they were sensitive to patients' enquires about disclosure and sensitive about patients' vulnerabilities (Paper 1). The process of being present is contingent on the patient demonstrating a need for and openness to the nurses presence, the nurse's willingness, and a conducive environment (Finfgeld-Connett, 2006). The characteristics of being present is similar to how the nurses in the study perceived being personal as integral to being professional (Paper 3). Like presence, being personal depends on the particular nurse-patient relationship and a contextual understanding.

Before I move on to discussing the potential negative consequences of boundary transgressions, I want to present an artwork that made a deep impression on me. Gilligan suggested that artists "are often far ahead in their perceptions [...] because they rely on associative methods that elude the cultural radar" (Gilligan, 2011, p. 85), and I think the artwork mentioned below taps into something that is essential to human relationships.

In 2010, The Museum of Modern Art in New York presented a performance retrospective of the performance artist Marina Abramović's work (The Museum of Modern Art, 2010). Abramović had created a new work for the performance retrospective, *The Artist Is Present*, which she performed daily throughout the exhibition. In *The Artist Is Present*, the rules were simple: Anyone visiting the exhibition was welcome to sit across from Abramović for as short or as long a time as they wanted. Abramović and the person sitting across from her would maintain

eye contact, but not touch or speak (Abramović & Kaplan, 2016). She performed for 736 hours and 1,675 persons sat across from her, one after the other (Abramović, 2017; Abramović & Kaplan, 2016). In her memoir, Abramović reflects on her experience during this performance: "What I found, immediately, was that people sitting across from me became very moved" (Abramović & Kaplan, 2016, p. 309). Abramović experienced a powerful connection to every person sitting across from her: "Hearts were opened to me, and I opened my heart in return, time after time. I opened my heart to each one, then closed my eyes – and then there was always another" (Abramović & Kaplan, 2016). In my opinion, Abramović's performance demonstrated how powerful the human connection could be when people are truly present in a relationship – even when the relationship only consists of a mutual gaze.

5.2.2 Strikes at the heart

While being personal certainly seems to have potential valuable benefits for nurse-patient relationships, the nurses in the study suggested it was not always easy to predict the fallout of their boundary decisions. Some nurses reported that their boundary decisions had unintended consequences. One nurse's self-disclosure of personal losses upset the patient who had experienced own losses (Paper 1). Another nurse found herself sharing more personal information than she was comfortable with (Paper 1). Yet another nurse felt burdened by a dual relationship she developed with a former patient (Paper 2). Pope and Keith-Spiegel (2008) note, "we may fail to consider a boundary crossing's potential future complications, unexpected developments, and unintended consequences." Situations may change in ways so that nurses are unable to foresee the implications of their boundary transgressions.

"The historical trend has been to cover up the damage and ignore the pain, guilt, grief, and rage characteristic of those who have survived boundary violations," claims Gabbard (2016, p. 143). However, in nursing literature, the consequences of blurred boundaries have been addressed decades ago in Travelbee's theory on interpersonal aspects of nursing (Travelbee, 1971). Travelbee describes how over-identification can make nurses too emotionally involved and enmeshed in the patients' problems to the extent where the nurse focuses on meeting her own needs instead of the patients' needs. It can be worthwhile to question nurses' assessments of what is in the patients' best interests. Can it be, for instance, that the dual relationships described by some of the nurses in the study (Paper 2), are primarily in the nurses' interest – and not the patient's?

Over-identification is related to the concept over-involvement, which includes "personal emotional attachment with extremes of behavior" (Jones et al., 2008, p. 358). Rescue fantasies is a form of over-involvement where the nurse believes her special care for the patient will heal

or save the patient (Gallop, 1998b). In some cases, as the one talked about by a nurse in the study, patients can declare that the nurse actually saved them (Paper 2). In such cases, patients' heartfelt gratitude can play into the nurses' rescue fantasies and inspire boundary transgressions like dual relationships. Travelbee's description of over-identification also resembles the concept *countertransference* – a psychological process of transference reactions toward patients. These reactions can make it difficult to distinguish between the needs and feelings of the patient and those of the nurse. Boundary violations "often result from confusion between the needs of the nurse and those of the patient" (Aylott, 2011, p. 811). The nurses in the study asserted the primacy of the patients' best interests, but they also acknowledged that their own interests and emotions affected the professional boundaries in their nurse-patient relationships (Paper 3).

The patients' vulnerability and need for help were important reasons for establishing and maintaining professional boundaries for the nurses in the study (Paper 3). Patients are vulnerable due to their mental illness (Jones, 2016, p. 50). In mental health care, many patients are also especially vulnerable because they have a history of traumatization and exploitation and their senses of appropriate boundaries may be impaired (Simon, 1992). Sadly, these patients seem to be especially at risk for professionals' boundary transgressions. Patients who have been emotionally deprived or abused as children can experience heightened *beneficent transference* – expressions of positive transference and expectations of beneficence from the professional (Simon, 1994, pp. 511-512). Because the patients are desperately yearning for help and hope, "the transferences and realistic expectations combined with the actual knowledge and skill disparities that exist between patient and caregiver leave some patients highly vulnerable to exploitation," according to Simon (1994, p. 512). Galletly (2004) claims that patients who have been previously sexually abused are especially exposed to sexual boundary violations. Some of the disciplinary cases from NBHS exemplify the link between a patient's history of abuse and later boundary violations from professionals. In one such NBHS disciplinary case, a patient who was involved in a sexual dual relationship with a nurse for seven and a half years, had been the victim of abuse (Statens helsetilsyn, 2014). In another disciplinary case, a patient who had been abused by her father, had sexual intercourse with a 24 year older nurse while in the nurse's care – which led to the nurse's license being revoked (Statens helsetilsyn, 2014). Patients with dependent or borderline personality disorders are also markedly at risk (Gutheil, 1989). If they are subject to boundary violations from the nurses who was supposed to help and support them, the consequences can be dramatic. Gabbard comments on the diversity of patients' reactions to boundary transgressions in psychoanalysis:

> In my own experience I have noted a spectrum from those who feel protective of their former analysts to those who have murderous rage against the analyst and have symptoms of posttraumatic stress disorder. Some patients will actually say that they feel unharmed by the sexual or nonsexual boundary violations and sound like advocates for their former analyst, who they feel has been unfairly treated. A significant number of patients will come to subsequent treatment with extraordinary ambivalence and a sense of not knowing what to believe about their previous analyst. Still others feel their lives have been destroyed and have difficulty functioning (Gabbard, 2016, p. 146).

The link between patients' mental health issues and susceptibility to boundary transgressions can have consequences for another aspect of boundary transgressions as well. Patients can be apprehensive about reporting boundary violations out of fear of being mistrusted. "Doubting has been a major factor in the victim's dilemma," claims Gabbard (2016, pp. 143-145) and explains that patient's concerns may be invalidated and attributed to the patient's pathology. Patients can be discredited because of their mental illnesses. The professionals' expertise may cause patients to doubt themselves and refrain from speaking up about boundary violations.

The disciplinary cases from the NBHS and The Norwegian Board of Health Personnel indicate that patients' reactions to boundary violations include worsened problems with anxiety and trust issues, feelings of betrayal, helplessness, abuse, shame, guilt, and grief (Statens helsetilsyn, 2014, 2017, 2018b). Patients can feel pressured, invaded, and pursued. The NBHS assesses that private relationships can cause patient's confusion and despair. The relationship with the professional can become a heavy burden, and boundary transgressions like dual relationships can become a hindrance to patients' recovery (Statens helsetilsyn, 2017).

Cessation trauma is a term used to describe the negative effects that can occur when a boundary transgressing relationship ends or changes character. Patients may have felt special, chosen, loved and cared for while the relationship was ongoing, only to feel devastated and traumatized when the professional discontinues it (Gutheil & Gabbard, 1992). This can apply to dual relationships like those described by some of the nurses in the study (Paper 2). Patients may have felt special to the nurses given that the dual relationships were exceptions to the rule of avoiding such relationships. Transference can create temporary improvements in patients, and when the dual relationship ends, patients can respond to the "transference disillusionment" (Simon, 1994, p. 512) with cessation trauma (Gutheil & Brodsky, 2011). Different behaviors that involve rejection can bring on cessation trauma, such as professionals' terminating the relationship or leaving for vacation (Gutheil & Gabbard, 1992). Nurses' rejection of patients can be experienced as offending the patients' dignity (Hem & Heggen,

2004). For some, setting boundaries can imply rejecting the patient (Grant & Mandell, 2016). The nurses' emphasis on not wanting to deny patients responses to their self-disclosure enquiries, can serve as an example of a situation where nurses avoid setting strict boundaries, and thereby reject the patient, and find ways to share a little, but not too much, in respect of the patient (Paper 1). Professionals can feel that setting boundaries means forsaking the patient (Statens helsetilsyn, 2017).

Cessation trauma can lead to "intense feelings of embarrassment and humiliation, severe disorganization, major depression, and suicidal crises" (Gutheil & Brodsky, 2011, p. 203). For patients in mental health care who are subject to professionals' boundary transgressions, "the insult of therapeutic misconduct is added to the injury of a mental disorder" (Simon, 1994, p. 513). Professionals' boundary transgressions can make the patients' situations worse. Not wanting to burden the patient was one of the reasons why the nurses in the study argued that strict boundaries were important if patients were in critical phases of their illness (Paper 3).

According to some of the nurses in the study, patients can misinterpret openness as a sign of a personal intimate relationship (Paper 3) or as competing for attention (Paper 1). Activities like casual meetings and friendly courtesies are "common, natural, and positive when they occur outside the context of psychotherapy, but often have different meanings and effects when they occur in the context of therapy" (Pope & Keith-Spiegel, 2008, p. 644). Different contexts call for different behaviors, as was evident in the nurses' emphasis on situations where self-disclosures felt *natural*, which can serve as an example of the power of context (Paper 1). In addition to the connections between context and actions' meanings, nurses and patients can understand boundary transgressions differently. "It is important to avoid mistaking the way we understand something for the way a client understands it," say Pope and Keith-Spiegel (2008, p. 645). In a disciplinary case from NBHS, a nurse who developed a long-lasting sexual dual relationship with a patient, claimed the relationship was mutual, while the patient felt abused (Statens helsetilsyn, 2014). Nurses' good intentions are no guarantee that boundary transgressions are beneficial to the patient: "One person's intended crossing may be another's perceived violation" (Barnett et al., 2007, p. 403). How patients' perceive boundary transgression can change over time. Dual relationships that patients perceived as true friendships or true love can look like abuse in hindsight. Professionals' own understanding of a boundary transgression can change as well. A nurse felt used after a sexual relationship with a much younger patient that initially rejected the nurse's advances, according to a NBHS disciplinary case (Statens helsetilsyn, 2014).

If nurses violate professional boundaries, it can lead to diminished trust in health services, and patients can become afraid of seeking help. The public's trust in the professionalism of health services is an important aspect of the NBHS's considerations in disciplinary cases. Patients, next of kin, colleagues, employers, and others must be able to trust that professionals do not exploit their position for their own gain or to satisfy their own needs (Statens helsetilsyn, 2018b). The public's trust in health services is necessary in order to provide help to those in need. The exploitation, that boundary transgressions can represent, "strikes at the heart of the patient's psyche—the critical ability to trust oneself and others" (Simon, 1994, p. 513).

In addition, nurses can act as gatekeepers to health services. The professional "has the specialized knowledge that will allow clients access to services they require," assert Jackson and Stevenson (2000, p. 383). This can ring true especially for health services in rural areas where health care options can be scarce. A nontherapeutic alliance can cause sabotaged treatment plans and "the patient can become isolated from much-needed supports and resources" (Pilette et al., 1995, p. 45). In the disciplinary case where a patient had a 7.5 year dual relationship with a nurse, the patient felt that she lost her treatment option because the nurse continued to work where the patient had received treatment (Statens helsetilsyn, 2014). In such situations, boundary transgressions can limit the therapeutic options for patients (Gallop, 1998b). Patients might be pressured to seek help from other professionals and other service providers. In a NBHS disciplinary case, the management at one psychiatric unit decided that the patient would be admitted to other psychiatric units in the future, after a nurse had been sending inappropriate text messages to the patient on several occasions (Statens helsetilsyn, 2012b). Norwegian patients' rights to choose freely among treatment centers in specialist health care services can ameliorate the limitation of treatment options, but might force patients to travel long distances to receive treatment.

The NBHS states that an important purpose with health services is to contribute to patients restoring their own health and function as independently of health personnel and health services as possible (Statens helsetilsyn, 2016, 2017). Nurses should avoid "becoming a substitute for significant others and increase the patient's dependency" (Hagen et al., 2017, p. 34). The nurse who accepted the role of aunt to a former patient's child may have become a substitute for significant others (Paper 2). Other nurses who enter friendships with patients might also become substitutes for potential friends the patient might have met without the nurse as a friend. One of the disciplinary cases from the NBHS provides a relevant example: A patient stated that her relationship with a psychologist affected her relationships with other friends and family (Statens helsetilsyn, 2017). Boundary violations can undercut the patient's

autonomy and independence (Simon, 1994). Professional boundaries can help ensure that patients do not rely too much on professionals and protect the patients' independence (Grant & Mandell, 2016).

Professionals can experience problems with regulating the balance between being close and being distant (Olsø et al., 2015), between distance and empathy (Eikeland et al., 2014). Nurses' can fear for their patients' well-being, but also for their own. "When patients had knowledge about and spoke offensively about the professionals' private and family issues, the latter experienced fear for their family and a feeling of humiliation," write Bachmann et al. (2016, p. 289). Patients' knowledge about the nurses' private life can feel like an intrusion. This was the case for one of the nurses in the study who quit working at her local community mental health services because it made professional boundaries difficult (Paper 3). Becoming too close to patients can become a burden (Bachmann et al., 2016). One of the nurses in the study shared a story about a dual relationship where she felt burdened and frustrated by the patient's worsened condition (Paper 2). One of the disciplinary cases from the NBHS involved a psychologist who had a similar experience. The patient whom he had a dual relationship with, called him and expressed suicidal thoughts, and the psychologist expressed that it became too burdensome to be the patient's "last chance" (Statens helsetilsyn, 2017). The nurse who had a 7.5-year dual relationship with a patient, tried to end the dual relationship for a year, but the patient reacted negatively and threatened to kill herself (Statens helsetilsyn, 2014).

The nurses in the study saw that professional boundaries were important to preventing burnout (Paper 3). A study on boundaries in community mental health services supports the nurses' perception, it reported that service providers saw boundaries as an important way to avoid burnout (Grant & Mandell, 2016). Together with vicarious traumatization, secondary traumatic stress, traumatic countertransference and compassion fatigue, burnout is one of the possible negative consequences of working with seriously traumatized people (S. Collins & Long, 2003; Isdal, 2017). Secondary exposure to trauma is a critical risk factor for burnout in the field of psychiatry and mental health care (Maslach & Leiter, 2016). It can cause professionals to detach or distance themselves from patients, or it might lead to over-involvement (S. Collins & Long, 2003). Burnout is also correlated with more negative feelings about patients and poor care (Maslach & Leiter, 2016). Emotional distance through professional boundaries helped protect the nurses in the study from burnout (Paper 3). "Finely tuned professional boundaries" contribute to sustain the professional self and prevent negative consequences such as burnout, according to Skovholt and Trotter-Mathison (2016, p. 159).

Nurses' ability to set appropriate professional boundaries can be related to professional maturity. Professionally mature nurses have "cultivated the ability to protect themselves and maintain a healthy emotional balance" so that they do not succumb to over emotional, destructive, controlling or self-centered forms of helping (Finfgeld-Connett, 2008, p. 200). A meta-synthesis of caring in nursing states that professional maturity is an antecedent to caring (Finfgeld-Connett, 2008). "Professionally mature nurses have developed a capacity for being deeply involved in the other without being overemotional, destructive, controlling or self-centred," writes Hem et al. (2014, p. 798). Professionally mature nurses possess self-awareness and self-confidence and have the ability to relate to their personal vulnerability (Finfgeld-Connett, 2008; Hem et al., 2014). The nurses in the study had years of experience as nurses and in mental health care. Their experiences was important to their professionalism and to their professional boundaries (Paper 3). Still, boundary issues like self-disclosure (Paper 1) and dual relationships (Paper 2) challenged their professional boundaries. Professional boundaries seemed to be a continuing negotiation between the nurses' personal preferences, professional distance, and the context in which the particular nurse-patient relationships took place.

6 Methodological considerations

There is debate on how to establish quality in qualitative research (Kvale & Brinkmann, 2015). Quality can be assessed and described differently depending on choice of perspective and terms (Creswell & Poth, 2017). Traditional criteria used in quantitative research, like rigor, reliability and validity, may have limited usefulness or different implications and applications in qualitative research (Holloway & Galvin, 2017). Alternatives like trustworthiness, authenticity, dependability, credibility and transferability have challenged the traditional criteria (Creswell & Poth, 2017; Fangen, 2010; Morse, 2015). Nevertheless, validity and reliability, in particular, remain important to assess quality in qualitative research (Creswell & Poth, 2017).

The textbooks I am most familiar with, focus on reflexivity, validity and reliability (Creswell & Poth, 2017; Fangen, 2010; Holloway & Galvin, 2017; Kvale & Brinkmann, 2015; Malterud, 2011, 2012), and I will focus on these criteria to consider the quality of my study. I will begin by discussing the study's validity, which includes reflexivity as a strategy for validation, and continue by discussing the study's reliability.

6.1 Validity

There is no unitary concept of validity in qualitative research (Holloway & Galvin, 2017, p. 303). Creswell and Poth (2017, pp. 254-255) provide an overview over perspectives and terms used for validation in qualitative research and state that "most use qualitative terms to describe validation that are distinct from quantitative terms; some combine or synthesize many perspectives or use a metaphor for visualizing it." I will refrain from going further into the debate on terminology related to quality in qualitative research. Instead, I will briefly discuss four common types of validity, before I go deeper into different strategies for validation. The strategies for validation seem to be independent of choice of terminology, the same strategies are referred to as increasing validity as e.g. increasing trustworthiness (Bazeley, 2013).

6.1.1 Validity x 4

The validity concept includes different types of validity: internal and external validity, and communicative and pragmatic validity (Fangen, 2010). *Internal validity* refers to "the extent to which the findings of a study are true, and whether they accurately reflect the aim of the research and the social reality of those participating in it" (Holloway & Galvin, 2017, pp. 305-306). Internal validity can be established to an extent by member checking, which I will return to in the discussion on validation strategies. Internal validity is also called construct validity (Fangen, 2010).

External validity is also called generalizability – however, transferability is suggested as a more useful and appropriate term for external validity in qualitative research (Holloway & Galvin, 2017). Either way, external validity refers to whether "the findings or conclusions of a research study can be applied to other similar settings and populations" (Holloway & Galvin, 2017, p. 306). The study does have some limitations regarding external validity. The fact that the study took place in an area that shares characteristics with rural nursing, with its social interconnectedness and close geographic proximity between nurses and patients, means that the results might not apply to nurses who work in urban areas. Many nurses working in mental health care in Norway are men. In my study, the majority of participants were women. Gender has not been a topic of discussion, and the gender perspective might have shed light on the issue of professional boundaries seeing that women often are considered to be more communicative and close in relationships. The youngest participant in the study was 40 years old. Age is a demographic variable that can influence nurses' perspectives on professional boundaries. Older people might be more self-assured, having gained confidence through experience. There can also be generational differences in culture. The study might therefore have limited transferability to younger nurses. Notwithstanding these limitations, the study's results can be applied to some similar settings and populations. The literature presented earlier in the thesis, particularly in the discussion on closing the professional distance (Chapter 5.2.1), suggests that the nurses in the study's experiences with the integration of being personal with being professional is familiar across different settings and populations, including different nursing settings, but also different professions.

Communicative validity involves assessing the validity of interpretations and observations through dialogues with others (Fangen, 2010, p. 237). These *others* can be the research participants, the general public and fellow researchers (Kvale & Brinkmann, 2015). Validation strategies can include member validation and peer review, both of which I will discuss later. Another aspect of communicative validity is the question of readability. If researchers do not manage to share, to communicate, the research findings in ways that others can comprehend, the knowledge remains private (Malterud, 2011, p. 185). Justifying choice of method and making assumptions and decisions transparent to readers is important in reports of qualitative research (O'Brien, Harris, Beckman, Reed, & Cook, 2014). Research reports need to balance academic language with accessibility. In my study, I have made an effort to present and publish in a language that, I hope, is understandable without compromising the integrity of the research.

Pragmatic validity refer to whether the knowledge developed through research contribute to improve on actions (Kvale & Brinkmann, 2015, pp. 285-286). Pragmatic validity is connected to *relevance* and addresses if and how knowledge is put to use (Malterud, 2011, p. 187). In my study, pragmatic validity may relate to how participants experienced the partaking in the study. Some of the participants mentioned that participating in the study had made them more conscientious about their professional boundaries and they experienced the study as a useful process of increasing awareness. I think it is important that I make the study's results available in different formats, like papers, lectures and seminars, in order to increase pragmatic validity. Luckily, as described related to ethical considerations (Chapter 3.7), I have had the opportunity to present the study at different seminars already, and hope to continue to do so.

6.1.2 Validation strategies

There are different strategies for validation in qualitative research (Creswell & Poth, 2017; Holloway & Galvin, 2017). Creswell and Poth (2017) advise that researchers engage in at least two strategies for validation in qualitative research. Some validation strategies aim at strengthening internal validity, while others aim at external validity.

Member checking, or member validation, is a strategy for increasing internal validation that involves presenting interpretations and findings to the participants in a study (Holloway & Galvin, 2017). Member validation can occur at different times in the research process (Malterud, 2011). While I interviewed the participants, I would frequently paraphrase or summarize what the participants were talking about to make sure I understood them correctly. The biggest misunderstandings happen when the people involved in the conversation do not even know that they are seeing things differently (Malterud, 2011). Later, in the process of writing and publishing paper 2, I presented the article draft to the participant who shared a story central to the article. The participant's reaction, confirming that my account of her experiences was accurate, was a relief and strengthened my trust in our (my co-authors and I) interpretations and presentations of findings. When participants accept the final description of their reality, like the descriptions in an article, at the same time as these descriptions open up for new insights and perhaps surprises, it is likely that we have developed knowledge that is rooted in the reality where it belongs, according to Malterud (2011). Nevertheless, there is no guarantee that participants will not object to disadvantageous descriptions (Fangen, 2010, p. 238). Member checking might be more appropriate for situations like the one mentioned, where I asked a participant about my account of her particular experience, than in situations where participants are asked about analysis. Morse (2015, p. 1216) claims that "the researcher's

background in theory and research methods must outrank the participant as a judge of the analysis" and does not recommend that type of member checking.

Triangulation is an important strategy for establishing external validity (Creswell & Poth, 2017; Holloway & Galvin, 2017). Triangulation is a way of establishing validity through examining a phenomenon from different perspectives, and there are different types of triangulation (Holloway & Galvin, 2017). In my study, I triangulated data and methods. I had multiple data sources: different practice settings (specialist mental health care and community mental health care) and times (day and evening shifts). I also used methodological triangulation by including participant observation, individual interviews and focus group interviews. Since these methods were qualitative, it means that my type of methodological triangulation was within-method as opposed to between-method (which would involve a mixed methods approach where qualitative and quantitative methods are used simultaneously or sequentially) (Holloway & Galvin, 2017). Triangulation can give more depth to the analysis and thus strengthen its validity (Holloway & Galvin, 2017).

Looking for negative cases and *alternative explanations* can enhance validity (Holloway & Galvin, 2017). This means identifying data that do not fit into developing theories, ideas or patterns (Holloway & Galvin, 2017). After identifying such negative (deviant) cases, the researcher must address and consider alternative explanations and interpretations of the data. In my study, I documented my own preconceptions early on, after the test interview, but before data collection with participants. I used the interview guide to explore my own experiences and my expectations of what participants in the study would answer. When I did my master's degree in criminology, I experienced that the prison officers that I interviewed emphasized certain unexpected aspects of the subject that I researched (they talked a lot about drug use as a common denominator in cruel criminal acts). To my surprise, my preconceptions in the PhD study largely matched the data and the findings. This made me worry. Why did my expectations match the participants' answers? Had my study just reproduced my own preconceptions? Had being an insider in the field made me especially insightful, or had being an insider made me blind to other answers that might have been there? Being an insider can make researchers take routines and practices for granted. "Many insider caregivers carry assumptions that may appear in the research, and be taken for granted," which makes it difficult to question care practices and examine them with new eyes (Morse, 2010, p. 1461). Had I been unable to look and ask for unexpected data and findings? The match between preconceptions and data was unsettling. The "pink elephant" bias is a concept that describes "the tendency for the researcher to see what is anticipated" (Morse, 2015, p. 1215). The pink

elephant paradox suggests that the ideas or concepts a researcher tries to avoid, becomes confirmed because the researcher begins believing in them once they are in her mind (Morse & Mitcham, 2002, p. 30). I had been able to identify unexpected data in my master's project, but, then again, I was not an insider to prison work. My supervisors in the PhD study were also insiders to mental health nursing, which might have limited our abilities to explore alternative perspectives. Negative cases, cases that differ from the commonly occurring cases in the data material, can reveal important differences (Morse, 2015, p. 1215). In my study, the nurses' who had experienced dual relationships with patients were fewer than those who did not have such experiences. The dual relationship cases were important to understanding how boundary transgressions could affect the nurses' private lives.

Supervision can be a form of *peer review*, which is a strategy for internal validation (Creswell & Poth, 2017). Peer review means letting competent colleagues "challenge coding decisions, interpretations and assumptions" (Holloway & Galvin, 2017, p. 314). It can "prevent bias and aid conceptual development of the study" (Morse, 2015, p. 1215). Two of my supervisors, Professor Vatne and Professor Hem, had access to raw data and were involved in analysis. Although the three of us are nurses with a background in mental health nursing, there were some important differences between us. These differences helped with challenging each other's interpretations and assumptions. An example is something that happened during the analysis of data related to dual relationships. Professor Vatne and I had prior knowledge of several dual relationships that had taken place in the local community, and we were not surprised by the extent and occurrence of dual relationship experiences among the participant nurses in the research project. Some of the dual relationship experiences were more surprising to professor Hem. Professor Hilde Lindemann (who is a philosopher and a bioethicist), whom I was lucky enough to have a talk with on June 2, 2015, said I had a moral obligation as a researcher to relate the nurses' experiences with dual relationships. In addition, I have presented rough drafts for articles and preliminary results to other colleagues and in research groups. These research groups consisted of colleagues from diverse professional backgrounds and not all of them were familiar with mental health nursing. In addition to supervisors and other colleagues, peer review is part of the publishing process. Editors and reviewers can provide very insightful comments on submitted journal articles (Fangen, 2010, p. 241).

An *audit trail* detailing the decisions made before and during the research and a description of the research process can give others opportunity to judge the research's validity (Holloway & Galvin, 2017). For my study, I kept a progress journal in the Evernote® note software where I documented the progress of the study. For most of the study's duration, I shared monthly

updates in the journal with my supervisors. This was a way to ensure their access to my progress, as well as a way for myself to keep track of events during the study. The progress journal became crucial to detailing for example how and when participants were recruited. In addition to the progress journal, I wrote over 250 other notes in Evernote® as well as handwritten notes in several notebooks. All notes are dated, which helps with tracking the chronological progress of the study. Evernote® proved very useful during the study with its options to tag and search notes, in addition to synchronizing across platforms and offline access to notes. The progress journal and the notes are complemented by several analytic documents, both digital and handwritten. I also found it useful to organize data in tables and charts, as well as using mind maps to explore and illustrate themes during analysis. All these documents contribute to the audit trail. While I had good use of many documents, I should have described some aspects of the research process in more detail. For example, in retrospect, I wish I had described my reasoning and deliberation more thoroughly.

Thick descriptions are a strategy linked to external validity (Creswell & Poth, 2017), and it is connected to the audit trail (Holloway & Galvin, 2017). By providing rich and detailed descriptions of the research process, participants, and contexts, readers can decide whether findings can be transferred to other settings (Creswell & Poth, 2017). Thick descriptions provide "a basis for the reader's evaluation of quality" (Holloway & Galvin, 2017, p. 315). Quotes can contribute to thick descriptions, and it is important to revisit raw data soon after its collection to "add further descriptions that might be helpful during the analysis" (Creswell & Poth, 2017, p. 263). Depending on each journal's preferences and reviews, I have included quotes in the three papers. Initially, I tried to write complex field notes from participant observation, following the recommendations of Fangen (2010) to write descriptive and thorough notes. I did not manage to follow through with that level of detail, and as a result, most of my field notes are quite superficial and simple. This may have limited their usefulness. However, I did make important notes that complemented interview data, and this has contributed to the level of detail in the thesis' descriptions of context and participants.

Prolonged engagement is necessary for thick descriptions (Holloway & Galvin, 2017). Prolonged engagement simply means "spending time in the setting" (Holloway & Galvin, 2017, p. 316). The assumption is that spending more time with participants increases trust, which makes participants reveal more, which leads to better and richer data, and thus more valid data (Morse, 2015, p. 1214). In my study, I would usually spend about 10 hours with each participant (6 hours participant observation, 2 hours individual interview and 2 hours focus group interview). By immersing oneself in the research setting, the researcher can make "field-based

decisions about what is salient to study" (Creswell & Poth, 2017, p. 262). Researchers who are familiar with the research setting, as I was, might have an advantage here. Even though I was familiar with the research setting, participant observation became very important to get to know the setting and the participants better. Data from participant observation directly influenced the individual interviews by providing situations that the participants and I could reflect upon in the interviews. In addition, I felt the time I spent with participants while observing was very important to building rapport. It felt as if I had gotten to know them enough so that I could ask questions that were more challenging and use less time introducing the topics in the interviews. Prolonged engagement also involves familiarizing oneself with sites and participants prior to data collection (Creswell & Poth, 2017). As I have described in the chapter about participants, many participants were acquainted with me prior to the study. Although I had not worked at any of the specific sites (as they were located and organized at the time of the study), mental health nursing has been my area of nursing work and I was familiar with the kind of nursing practice that takes place within such settings.

Reflexivity is important to validity in qualitative research (Creswell & Poth, 2017). Reflexivity means disclosing understandings about the biases, values and experiences that the researcher brings to the study (Creswell & Poth, 2017). The researcher must critically reflect upon her own preconceptions and reactions (Holloway & Galvin, 2017). Chapter 3.6 provides important details in this respect, but reflexivity is an ongoing process throughout the research process (Holloway & Galvin, 2017). Reflections are therefore included throughout the thesis to account for the close connections between my experiences and perspectives and the methodological choices I have made. Creswell and Poth (2017) mention that the researcher's use of specific validation strategies can be linked to the researcher's philosophical orientation. This study is anchored in the tradition of *hermeneutic phenomenology*, which places emphasis on interpretation, reflexivity and the researcher's role and position with regard to co-creating data.

6.2 Reliability

Reliability refers to the consistency and credibility of the research results (Kvale & Brinkmann, 2015). Reliability is connected to the question of whether research results can be reproduced at other times by other researchers (Kvale & Brinkmann, 2015). I will briefly address some issues regarding reliability in qualitative research and relate this to my study.

"As the researcher is the main research instrument in qualitative inquiry, the research can never be wholly replicable," assert Holloway and Galvin (2017, p. 305). Even if other researchers use the same methods, similar samples and topics, they would probably emphasize differently.

In a way, a researcher cannot even replicate her own research because her preconceptions would have changed. My position affected the research through the choices I made along the way. Positioning makes it mark on each step of the research process. Fangen (2010, p. 250) states that reproducing research results is impossible in studies using participant observation, and she makes an argument for considering alternative data and analysis supplementary or complementary as long as they do not contradict the original research. Field notes are important to assess reliability in studies using participant observation. Field notes should be as descriptive and concrete as possible and the level of detail must match the purpose of the observations (Fangen, 2010). Since observations in my study focused on what personal information the participants shared, I thought it was easy to make the field notes descriptive and concrete. My preconceptions (of what was personal information) influenced what I noted, and another researcher might have noticed other types of personal information.

Kvale and Brinkmann (2015, p. 203) claim that there are no unambiguous quality criteria for qualitative research interviews, and that assessments of interview quality depend on the interview's specific design, theme and purpose. In qualitative interviews, interview reliability applies to the interviewer, to the transcription and to analysis. Different researchers can transcribe recorded audio from interviews differently depending on transcription choices and what they think they hear (Kvale & Brinkmann, 2015). In my study, I shared a dialect with some of the participants, which made it easier to be certain of what they said. Participants with other dialects could be more challenging to understand, and another researcher might have heard and transcribed words differently. Coding reliability, whether coding is consistent across multiple coders, is a term adopted from quantitative research, which can be difficult to transfer to qualitative interviews (Bazeley, 2013). "Most samples of qualitative data have multiple stories to tell, and each person coming to the data brings with them their own purposes, perspectives, experiences, and knowledge," says Bazeley (2013, p. 150). In my study, discussions with supervisors Professor Vatne and Professor Hem was important to the analytic process. Together, we questioned and contemplated the codes, preliminary themes, and subthemes. Discussions were not aimed at determining coder reliability, but seeing if we could come to a mutual understanding of important themes. Bazeley (2013, p. 151) says it well, stating that the real value of measuring reliability lies in promoting "some very worthwhile decisions about how the coding is being approached, based on the differences observed, leading to agreement about what is important (hopefully!), and clear definitions for categories."

7 Conclusion

The study's most important contribution to the research field is that it describes how nurses deal with some urgent boundary issues in relationships with patients in mental health care. The study suggests that nurses have to deal with difficult boundary decisions mostly on their own – decisions that can have huge consequences for themselves and their patients. The study is one of few empirical studies on nurses' professional boundaries in mental health care.

The study supports previous research in some respects. The study supports research that acknowledges the diverse reasons for self-disclosure in therapeutic relationships. Self-disclosure can have beneficial effects, such as increased similarity and decreased asymmetry, in the nurse-patient relationship. The potential for beneficial effects is no guarantee though. Patients may respond differently than expected. The study supports research that describes the many dilemmas related to dual relationships, especially in rural settings where some dual relationships can be unavoidable. Dual relationships with current and/or former patients can violate legal acts and result in disciplinary sanctions.

Overall, the study falls in line with research emphasizing the importance of context. The study demonstrated how boundary issues, like self-disclosure and dual relationships, depend on case-by-case consideration. Professional boundaries in mental health nursing are situated and relational, which opposes rigid rules of professional conduct.

8 Implications for nursing practice

An emphasis on boundary issues in nursing education might help with nurses' practice of professional boundaries. Topics can include specific boundary issues (like self-disclosure and dual relationships), models for and training in ethical deliberation, relevant health legislation, and professional boundaries' role in preventing burnout, compassion fatigue and secondary traumatization.

In nursing practice, it is important that nurses make use of their colleagues and supervisors when they face boundary decisions. Colleagues and supervisors can contribute by engaging in ethical deliberation related to specific cases involving boundary issues. Employers can assist nurses' professional boundaries by providing supervision and guidelines based on health law.

It is important to remember that professional boundaries serve to protect patients who are vulnerable due to their illnesses. If nurses fail to establish and maintain appropriate boundaries, they need to be advised or, in more serious cases, reported to a disciplinary board.

9 Suggestions for further research

The work with this study has made me curious about other aspects of professional boundaries, and based on the literature I have reviewed, I think there are some aspects that would benefit from further research.

Considering that boundary transgressions seem to have the potential to increase chances of recovery, it would be important to learn more about patients' experiences with nurses' boundary transgressions. The patients' perspectives on dual relationships would be a very important and interesting angle.

In Norway, there is an increased emphasis on peer support by involving and employing persons who have experiences with for example mental illness and drug addiction in mental health care services. Peer workers are considered qualified to provide help based on their personal experiences. This could pose several challenges to professional boundaries, perhaps especially in treatment of drug addiction where patients and peer workers might have been doing drugs together previously. It would be interesting to explore how peer workers manage professional boundaries, and how patients respond to peer support.

Mental health care in Norway covers both larger cities, small cities, villages and other rural areas. Depending on the local supply of care services, nurses and patients can have limited options regarding whom they meet. This study took place in an area where nurses and patients experience meeting people with whom they have prior personal relationships with, or they meet each other accidentally in the local community. This means that the issue of professional boundaries can become even more pressing than in urban areas with more treatment options. Further research could go deeper into how nurses and patients deal with this interconnectedness.

Boundary issues are not limited to certain professions, and further research could benefit from seeing past specific professions. It might also be valuable to see if various professions experience boundary issues differently.

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ORIGINAL ARTICLE

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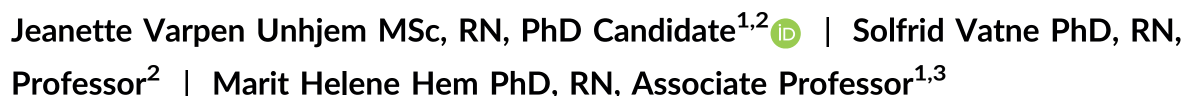
Transforming nurse–patient relationships—A qualitative study of nurse self-disclosure in mental health care



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Aims and objectives: To describe what and why nurses self-disclose to patients in mental health care.

Background: Self-disclosure is common, but controversial and difficult to delineate. Extant research suggests that self-disclosure might have several potentially beneficial effects on therapeutic alliance and treatment outcome for patients in mental health care, but results are often mixed and limited by definitional inconsistencies.

Design: Multi-site study with purposive sampling and source triangulation.

Method: Qualitative descriptive study including data from 16 nurses taking part in participant observation, individual interviews and focus group interviews.

Results: Separate analyses resulted in four themes addressing the research question of *what* nurses self-disclose, and one main theme and four subthemes addressing *why* nurses self-disclose. The content of self-disclosure was captured in the four themes: Immediate family, Interests and activities, Life experiences and Identity. In addition, results showed that disclosures were common among the nurses. Self-disclosure's potential to transform the nurse–patient relationship, making it more open, honest, close, reciprocal and equal, was the overarching reason why nurses shared personal information. The nurses also chose to self-disclose to share existential and everyday sentiments, to give real-life advice, because it felt natural and responsive to patients' question to do so.

Conclusion: Nurse self-disclosure is common and cover a variety of personal information. Nurses have several reasons for choosing to self-disclose, most of which are connected to improving the nurse–patient relationship.

Relevance to clinical practice: Self-disclosure controversy can make it difficult for nurses to know whether they should share personal information or not. Insights into the diversity of and reasons for nurse self-disclosure can help with deliberations on self-disclosure.

KEYWORDS
mental health nursing, nurse–patient relationship, professional boundaries, qualitative study, therapeutic relationships

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1 | INTRODUCTION

Self-disclosure by health professionals is a common practice, but there is still controversy regarding when it is appropriate, what the extent and content of self-disclosure should be, and what the clinical and ethical consequences are (Reamer, 2012). These questions regarding self-disclosure concern any health professional and their relationship with patients. However, much research has focused on therapists and psychotherapy. In addition, delineating self-disclosure can prove difficult due to definitional inconsistencies (McCarthy Veach, 2011).

The aim of this article was to explore the content of and reasons for nurse self-disclosure in mental health care. For this article's purpose, *self-disclosure* is defined as a nurse's verbal and voluntary disclosure of personal information, including demographical and biographical details, personal insights, coping strategies and so forth, to a patient (Ziv-Beiman, 2013; Zur, Williams, Lehavot, & Knapp, 2009). The study is part of a larger research project focusing on what it means to be professional, personal and private in nurse–patient relationships in mental health care.

What does this paper contribute to the wider global clinical community?

- Nurse self-disclosure is common and cover different types of personal information.
- The main reason why nurses self-disclose is to make the nurse–patient relationship more open, honest, close, reciprocal and equal.
- Nurse self-disclosure can be linked to the nurse's role and the mental health nursing setting.

2 | BACKGROUND

2.1 | The origins of self-disclosure

The term *self-disclosure* has been attributed to Sidney M. Jourard, and he defines it as "the act of making yourself manifest, showing yourself so others can perceive you" (Jourard, 1971). One important contribution by Jourard is his account of the dyadic effect which refers to the reciprocity that self-disclosure often evokes: disclosure begets disclosure (Jourard, 1971). The dyadic effect is supported by research findings which suggest that patients are more likely to disclose to a self-disclosing counsellor, albeit this effect is not significant in other studies (Henretty, Currier, Berman, & Levitt, 2014; Henretty & Levitt, 2010). Jourard's works are part of the humanistic and existential traditions that tend to promote self-disclosure (Ziv-Beiman, 2013).

2.2 | Self-disclosure's role in the therapeutic relationship

Proponents of some psychoanalytic schools have been far more sceptical about self-disclosure than Jourard. This stems back to Freud's ideal of the therapist as a blank screen, intending to give patients' transferences ample room (Henretty & Levitt, 2010). Nowadays, most agree that therapist self-disclosure is inevitable, and some acknowledge its value as a potentially beneficial intervention (Berg, Antonsen, & Binder, 2016; Yalom, 2002; Ziv-Beiman, 2013). Therapist self-disclosure's place within different theoretical positions has been reviewed by several researchers (Hill & Knox, 2002; Ziv-Beiman, 2013). Carl R. Rogers is worth mentioning given his invaluable contribution to person-centeredness in mental health care. Rogers emphasises genuineness, unconditional positive regard and empathy as three of six conditions that are necessary in a therapeutic relationship if constructive personality change is to occur (Rogers, 1957). Rogers does not limit these conditions to psychotherapy or to therapists, but postulates that these three conditions obtain in any situation and depend on experience which may or may not be part of professional education (Rogers, 1957). Rogers insists that health professionals need to meet patients on a person-to-person basis, being genuinely themselves and not limiting themselves to a professional role that might make it more difficult to relate to patients in genuine and empathic ways (Rogers & Stevens, 1967). Rogers believes that being genuine and transparent in a relationship will help others cope with their problems (Rogers, 1961).

In regard to the field of nursing, Hildegard E. Peplau's theory of interpersonal relationships has been important to the development of mental health nursing (Hummelvoll, 1996). However, in contrast to Rogers' view of the professional role, Peplau argues for "professional closeness," a role characterised by nurses' detached self-interest and exclusive focus on the patient's interest (Peplau, 1969). Peplau's stance on nurse self-disclosure is one of dismissal, assuming that self-disclosure is always nontherapeutic (Coolidge Young, 1988). She claims that there is no need for a patient to have information about the personal life of a nurse (Peplau, 1997). Peplau sees nurse self-disclosure as a threat to nurses' focus on the patient, arguing that nurses who focus on their personal experiences put the patient into the role of chum. She points to innumerable nonpersonal subjects of common interest which would be more appropriate for social conversations with patients (Peplau, 1960, 1969). Contemporary nursing literature is more in line with Rogers' view, stating that nurse self-disclosure can be an expression of genuineness and honesty (Stuart, 2013).

2.3 | Definitional inconsistency

There has been considerable definitional inconsistency in research regarding self-disclosure (McCarthy Veach, 2011). This article defines *self-disclosure* as verbal and voluntary disclosure of personal information, including demographical and biographical details, personal insights, coping strategies and so forth. Self-disclosure and self-involving responses are covered by the term *self-reference*, but some have used the term *self-disclosure* when investigating *self-involving* responses as well (McCarthy Veach, 2011). While *self-disclosure*

often refer to *nonimmediate disclosure*, *self-involving* responses are *immediate*, consisting of self-involving feelings and attitudes towards the patient, or information about the health professional's education or approach (Ziv-Beiman, 2013). *Countertransference disclosures* are considered indistinguishable from immediacy disclosures (Farber, 2006). In addition, self-disclosure definitions sometimes focus on thematic content, degrees of depth (quality) and breadth (quantity) that refer to the intimacy level and the amount of the personal information disclosed (Collins & Miller, 1994). Another distinction can be made between intra- and extratherapy disclosures and yet another between different subtypes of self-disclosures (Henretty et al., 2014; Hill & Knox, 2002). One set of types of self-disclosure differentiates between deliberate, unavoidable and accidental self-disclosure (Zur et al., 2009). Mental health nursing curricula define self-disclosure as intentional and genuine personal statements about the self (Fisher, McCarthy, & Sweeney, 2016; Stuart, 2013). Like other definitions, this last one also includes aspects that overlap with parts of different definitions by addressing the self-disclosure content (genuine and personal statements) and how it is delivered (intentionally).

2.4 | Benefits of self-disclosure

Different theoretical stances and definitional inconsistencies aside, self-disclosure proves to be common (Arroll & Allen, 2015; Henretty & Levitt, 2010; Levitt et al., 2016). The variety of reasons for self-disclosure can help explain why it is common. Previous research has described reasons that include, but are not limited to, increasing perceived similarity, modelling appropriate behaviour, strengthening therapeutic alliance, validating reality or normalising experiences, offering alternative strategies and responding to a patient's personal questions (Hill & Knox, 2002). In addition, therapeutic use of nurse self-disclosure has been suggested to have potential positive effects on the nurse–patient relationship, such as enhancing trust and decreasing role distancing (Ashmore & Banks, 2002).

Outcome reviews report conflicting data related to the consequences of self-disclosure (Arroll & Allen, 2015). This may be explained by variations in context, relationship quality and disclosure content (Arroll & Allen, 2015). In a psychotherapy or counselling context, self-involving responses are believed to yield more positive outcomes than self-disclosing responses (Henretty & Levitt, 2010; Henretty et al., 2014). Even so, a study of clients' perceptions of self-disclosure found that self-revelations were no more or less helpful than self-involving disclosures (Hanson, 2005). One review found self-disclosure to have positive outcomes pertaining to rapport building and alliance strengthening with some patients, increasing the likelihood of patient self-disclosure, making the health personnel seem more similar to the patient (Henretty et al., 2014). Another review pointed out that different types and functions of self-disclosure appeared to be differently associated with outcomes (Levitt et al., 2016). A much-cited review found mixed results or no clear effects of self-disclosure on most of the variables it investigated, but found positive effects of self-disclosure on perceptions of therapist's warmth, clients' liking of therapists, client self-disclosure and positive responses from clients (Henretty & Levitt, 2010). Alas, some of these research findings might have limited usefulness for both research and practice because of definitional inconsistencies (McCarthy Veach, 2011).

2.5 | Deliberating self-disclosure

Even if self-disclosure can have positive outcomes, there are good reasons to use caution. First of all, there are considerable difficulties predicting patients' responses to health professionals' self-disclosures (Peterson, 2002). Second, different patient groups can have diverging reactions to self-disclosure (Goldstein, 1997; Gutheil & Brodsky, 2011). A study on self-disclosure from the client perspective presented findings on how health professionals' self-disclosure was hindering the therapeutic relationship by leading to role confusion and role reversal, and feelings of being misunderstood and overwhelmed (Audet & Everall, 2010). Unhelpful disclosures can decrease patients' feelings of trust and safety and damage the therapeutic alliance, but so can nondisclosures (Hanson, 2005).

The literature on self-disclosure includes guidelines to help health professionals determine whether, when, what and how to self-disclose. One review posits the following advice: self-disclosure should be infrequent, deliberate, and carefully worded, and the self-discloser should be responsive to their patient before, during and after a self-disclosure, in addition to returning the focus to the patient immediately after a disclosure (Henretty & Levitt, 2010). Another study adds to the above by suggesting that self-disclosures which are humanising and convey similarity are beneficial (Levitt et al., 2016).

2.6 | Current challenges

Given the complexities of health professionals' self-disclosure and the far reach of its relevance, it is important to explore self-disclosure further. With recovery-oriented practice gaining further ground, person-to-person-centred practice strengthens its position within mental health care (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Studies have shown that patients expect health professionals to relate to them as friendly professionals, sharing intimate information that is relevant and therapeutic (Audet & Everall, 2010; Jackson & Stevenson, 1998, 2000). Yet, some nursing practice settings can instil nurses with a resistance to self-disclosure (Price, Burbery, Leonard, & Doyle, 2016). This can pose challenges to health professionals and their therapeutic use of self and self-disclosure.

3 | AIM

To describe what nurses self-disclose to patients in mental health care and what reasons they have for self-disclosure.

4 | METHODS

This study employed a qualitative descriptive design and utilised source triangulation with data from participant observation,

individual interviews and focus group interviews. A qualitative approach with multiple forms of data is preferable when there is a need for a complex and detailed understanding of a phenomenon (Creswell & Poth, 2017).

4.1 | Research context

Data were collected in four units (including open and closed units) and three districts located in a small town and rural villages in mid-Norway that attended to adult patients with a variety of mental health diagnoses and challenges. As in many other countries, current Norwegian mental health nursing emphasises the importance of a therapeutic nurse–patient relationship and a recovery-oriented practice (Leamy et al., 2011; Slade et al., 2014).

4.2 | Participants

Participants were recruited through purposive sampling of nurses working in local mental health services. Sixteen registered nurses volunteered to participate. Eight nurses were recruited indirectly through formal requests, two after being encouraged by a participating colleague and six after meeting with the researcher directly. Recruitment was discontinued after exceeding the planned sample size (12 participants) which was based on reflections on sample sizes in qualitative research employing individual interviews (Malterud, 2011). Participant characteristics are summarised in Table 1.

4.3 | Data collection

Data collection lasted from July 2013–March 2014. Observations took place at each nurse's place of employment and focused on what kind of personal information the nurse shared. Fourteen nurses were observed twice. One nurse was observed only once, and another nurse was observed three times. Observations lasted approximately 4 hr in day or evening shifts and were documented in field notes. The nurses were interviewed individually before participating in focus groups. Individual interviews were semi-structured with an interview guide that covered predetermined themes and revisited observed situations (Table 2). Most individual interviews took place where the nurses worked, except one at the first author's office by the nurse's choice. Three nurses were interviewed individually three times, the rest twice. Two nurses were asked to give a third interview to expand on particularly interesting experiences. One was asked to give a third interview to recollect the content of the second interview because the recording malfunctioned. Individual interviews lasted between 46 min–1 hr and 47 min. Focus group interviews were conducted in a meeting room at the local university college, lasted about 2 hr each and had three to five participants. A vignette displaying a self-disclosure dilemma was employed to spur discussion (Table 3). Three nurses were unable to participate. A comoderator assisted in focus group interviews. Individual interviews and focus group interviews were recorded digitally and transcribed verbatim.

4.4 | Data analysis

Field notes from participant observation provided data relevant to answering the first research question. Systematic text condensation served as an analytical framework (Malterud, 2001). Field notes were imported into the qualitative data analysis software NVivo, version 10, and coded into nine groups after a thorough read-through. Each group of codes was examined closely and rearranged into four overarching themes where each theme specified a type of self-disclosure content: Immediate family, Interests and activities, Life experiences and Identity. Finally, theme descriptions were developed. The level of abstraction varied across themes; for example, the theme Identity, with its data related to displays of opinions and personality, demanded more abstraction than the theme Immediate family, which covers information connected to categories such as spouses and children (Table 4).

Field notes from participant observations and transcripts from individual interviews and focus group interviews provided data to answer the second research question. NVivo, version 11, was used

TABLE 1 Participant characteristics

Characteristics	Participants (N = 16)	Mean (Range)
Age		52 (40–60)
Gender		
Male	3	
Female	13	
Registered nurse (No. of years)		21 (5–37)
Care setting		
Specialist mental health care	12	
Communal mental health care	4	
Specialisation in mental health care		
Yes	15	
No	1	

TABLE 2 Excerpt from semi-structured interview guide

Patients who you have gotten to know especially well
Use of self
Situations where you have felt you shared too much
The difference between personal and private

TABLE 3 Focus group vignette

A patient needs help after a difficult relationship break-up
The nurse speaks with the patient, and the patient talks about being in despair
The nurse has experienced relationship break-up
Should the nurse share her personal experience with the patient?

TABLE 4 Example of systematic text condensation

Field note	Preliminary theme	Condensed meaning unit	Theme
Says he likes to talk	Personality	Who and how I am	Identity
Mentions that she sometimes likes an argument	Personality	Who and how I am	Identity
Shares an opinion on a controversial local issue	Opinion	Who and how I am	Identity

to code the comprehensive data material of approximately 800 text pages. A less stringent analysis process was applied to prevent missing important nuances in the data set. By conducting all observations and interviews and transcribing by herself, the first author was quite familiar with the data material. Preliminary themes were coded consecutively. The interpretative process at this point revolved around identifying potentially meaningful parts of the text, and asking the questions: How does this answer why nurses self-disclose, and what does it mean? Repeated readings led to recoding parts of the text and revising themes. Each preliminary theme was recontextualised to determine whether it provided an answer that represented the meaning inherent in the data material. NVivo coding and development of themes were made by the first author. The second and third authors participated in discussing and revising theme descriptions. A final revision resulted in a main theme—Transforming the nurse–patient relationship—and four subthemes: Sharing existential and everyday sentiments, Giving real-life advice, Feeling natural and Responding to patients' questions.

4.5 | Ethical considerations

The study was registered in April 2013 with the Norwegian Social Science Data Services (project number 34079: "Being Professional, Personal and Private in Nurse-patient Relationships"). A request for permission to conduct the research project was sent to the regional mental health services administration. The administration accepted and forwarded the request. The researcher followed up with personal contact. Participants were given detailed information, verbally and in writing, about the research project's aims, methods and potential benefits and downsides. Participating nurses signed a consent form. Some defining characteristics have been changed (e.g., names) to ensure research participants' anonymity and protect confidentiality, while still preserving the validity of the data.

5 | RESULTS

Results are presented in two sections where the first section briefly describes contents of nurse self-disclosure, and the second provides a deeper insight into reasons behind nurse self-disclosure.

5.1 | What do nurses self-disclose?

Analysis revealed that nurses' self-disclosure can be described by four themes representing different types of disclosure content: Immediate family, Interests and activities, Life experiences and Identity (see examples in Table 5). These types of disclosure content were common among the participants as all disclosed at least one type of personal information, and 11 of the 16 participant nurses disclosed personal information from each of the four themes during observations. Nurses self-disclose while talking to patients one-on-one, but also in conversations with other health professionals and/or more than one patient. Sometimes conversations between colleagues take on personal themes while patients are present in the room but not part of the conversation. Sometimes self-disclosures seemed to be closely connected to patients' self-disclosures as when Monica shared a life experience while tending to a patient's self-inflicted wounds:

> *The patient says she wants to tattoo her arms to cover the scars from self-harm. Monica discloses that she has a tattoo and piercings and shares the story behind them, saying that it was a way to mark completing different studies and that she did it together with some fellow students.*

5.2 | Why do nurses self-disclose?

Nurses' reasons for self-disclosure were related to changing the dynamics of the nurse–patient relationship. The nurses perceived their disclosures of personal information as an invaluable contribution towards making the nurse–patient relationship more open,

TABLE 5 Self-disclosure content

Immediate family	Interests and activities	Life Experiences	Identity
Personal information about spouses, children, grandchildren, siblings and parents. Most mentions was about the nurses' children, their children's interests or activities, or about spending time with their children	After work interests and activities Cats, dogs, shopping and travelling Sharing personal information about what they have been doing during their off hours	Stories cover subjects such as childhood memories, family traditions, education experiences, work experiences, health issues and information about where the nurses live	Many nurses wear ID tags Talk about their personality and personal opinions on different subjects

honest, close, reciprocal and equal. By sharing something personal that is relevant to that particular patient in that particular situation, the nurse can make common interests known by sharing something similar. By giving something of herself, the nurse makes talking with her more interesting, and this can lead to the nurse getting more in return as well. Sharing something personal about themselves provides nurses with an opportunity to promote equality and sharing in the nurse–patient relationship. The nurses emphasised the therapeutic value of self-disclosure. Nurse self-disclosures can carry within them a message that have the power to transform the dynamics of the nurse–patient relationship and make a therapeutic relationship possible:

> *They give out their whole life story, the most vulnerable in their lives, to us. So if I cannot have some balance, be able to say something about myself, without laying out everything about my private life… I want to be able to say that, yes, I have kids, yes, so your kids and mine are the same age. And it can almost become a conversation starter many times.* (Nina)

5.2.1 | Sharing existential and everyday sentiments

Nurses and patients alike have to deal with a wide range of emotions and experiences in their lives. Some of patients' struggles can be easy to relate to because the nurses have similar experiences, and nurses can communicate deep understanding and sincere support by disclosing these. At the same time, even if intentions are good, self-disclosures do not always come across as understanding and supportive. Nina experienced this when she told a patient who had lost her child, about her own experience with family loss. The patient later revealed that she felt Nina tried to compete with her grief. However, not every commonality has to involve a crisis of some sort. Nurses and patients can also share experiences about everyday joys and challenges. Having children of the same age can be one such thing. Nurses and patients can also find that they have interests in common, and some nurses readily tell patients so if the opportunity presents itself. Being open about common experiences can also be a way to normalise patient experiences. For some nurses, it is important to emphasise a shared humanity. Sharing personal information that demonstrates that nurses and patients are alike can be an expression of this shared humanity. Sometimes, nurses emphasise their own shortcomings in an effort to normalise weaknesses and possibly build patients' confidence. Patients sometimes see nurses as infallible and can underestimate the challenges nurses have dealt with. Nurses' self-disclosures can be a reminder that everybody experiences difficulties from time to time:

> *One of my patients, Paul, is very interested in animals. When one of his dogs died, he was devastated. Even though I thought Paul overreacted, it felt good that I was able to say that I could relate to his loss. I told Paul that my family cried when our dog was run over and killed by a car, that it was a very sad time for my family. I know it is good to get to talk about it, especially since when you are adult, people usually say that you just have to pull yourself together, that it was just an animal.* (Sarah)

5.2.2 | Giving real-life advice

A nurse's life experiences can provide valuable insights and help the nurse give meaningful advice. Although this often happens indirectly, without the nurse admitting to particular experiences, sometimes nurses find it useful to talk to patients openly about how they handled specific challenges in their lives. These types of advice can be contingent on the nurse's having worked through the issues at hand and on the advice providing strategies that can contribute positively to the patient's mastering of his or hers problems. Sometimes, nurses volunteer advice, and, other times, patients enquire about nurses' experiences. The nurses were concerned about the usefulness of their advice and focused on advice that would encourage the patients to deal with challenges and move on with their lives. Lisa's daughter took her own life, and Lisa had shared her experience with her daughter's suicide with some patients. The story of her daughter's suicide had been shared to communicate different messages. For one, it was a story to show that it is possible to go on with your life even after losing a child to suicide. In addition, it was a story that could challenge a suicidal patient's thought that his family would be better off without him. Nurses' self-disclosures can represent a form of experience-based advice that might help patients deal with specific challenges. By drawing from their own experiences with overcoming difficulties, nurses dispense advice that they know to be helpful. In this sense, nurses grasp the opportunity to make personal experiences useful for their patients:

> *The patient that I am following closely up on now, she asked me if I live alone. Yes, I do, I told her. My children are all grown up and have moved out, and I do not have a husband any more. She is afraid to live alone and worries about being discharged and having to live by herself. She would rather live in a shared apartment where she could have health professionals nearby all the time. So letting her know that people can live alone and have a good life, I thought that that could be useful for her. [Living alone] I can do as I want, have visitors when I want, and be away when I want to.* (Emma)

5.2.3 | Feeling natural

In some situations and with some patients, disclosing personal information can feel like a natural part of a conversation. Context is critical, and nurses' perceptions of the quality of the nurse–patient relationship influence whether sharing personal information feels

natural or not. Nurses and patients can get to know each other and develop trusting relationships, sometimes because these relationships last for years. In these relationships, nurses might feel that it is "more natural to open up for [...] personal, private thoughts and emotions." In addition, the power of "there and then" sometimes lures nurses to disclose more than they actually are comfortable with sharing. Nurses sometimes find themselves letting personal information slip because it felt natural at that particular place and time. Even if a nurse has decided beforehand on what she wants to disclose or not, sometimes conversations do not go as planned. The presence of other health professionals might also contribute to nurses revealing information that is more personal. What feels natural "there and then" can determine what nurses self-disclose in many situations:

> *Yesterday I talked with a patient that I have a really good relationship with. She is also a nurse. She is 68 years old and retired. And there in her room, she has this book, and inside the book's covers she keeps pictures of her kids. To her, so much of her identity revolves around being a mother and a grandmother, right. So she, while I am looking at her pictures, she asks: Do you have children? And there and then it feels natural to me to tell her about my kids and what they do, right. But there are not many of my patients who know the things that I told her yesterday.* (Ellen)

5.2.4 | Answering patients' questions

Nurse self-disclosures are sometimes requested by patients, and nurses consider if and how to reply. Few nurses refuse to answer, but instead aim at balancing sharing not too little and not too much. The difficulty with denying a patient an answer can be linked to nurses' wanting to even out the disproportioned amounts of personal information in the nurse–patient relationship. It can also be linked to nurses' perceptions of how wrong it can be to not provide answers to simple questions. Nurses might want to protect their privacy and sometimes do this by limiting details when answering patients' questions. Nurses can also be aware that their answers might make patients feel uncomfortable for different reasons and sometimes withhold or play down their own successfulness to be considerate of patients' feelings. Patients can become familiar with parts of nurses' lives through long-lasting nurse–patient relationships because they have common acquaintances or live in the same area. This can inspire personal questions from patients. Requests for nurse self-disclosure vary among patients, and although some patients are especially inquisitive, nurses experience and appreciate other patients being respectful of a nurse's right to privacy:

> *I think about it sometimes, that patients reveal so much about themselves, their inner self and their hardest... So if you, if I get a direct question: Nina, are you married, do you have kids? I think, it is terribly difficult to say, you know, this is private, the focus should not be on me. So then I answer, of course, I have two children and so on, but I do not need to say any more about them. But then I feel that I have shared a little without saying too much.* (Nina)

6 | DISCUSSION

6.1 | A multitude of self-disclosures

This study's results indicate that self-disclosure is common among nurses. This supports previous research findings stating that health professional self-disclosure is a common practice (Henretty & Levitt, 2010; Reamer, 2012). In addition, it is clear that nurses' self-disclosures are not limited to some sparse personal titbits, but cover a wide range of personal information. Defining types of self-disclosure can prove difficult because they are not always as distinct as first impressions suggest (McCarthy Veach, 2011). A distinction can be made between disclosure types referring to content versus disclosure types referring to function. This distinction can be important, seeing as the same self-disclosure content can have different functions depending on the situation (Pinto-Coelho, Hill, & Kivlighan, 2016). The different types of personal information shared by the nurses in this study are represented by four themes reflecting disclosure content. Contrary to Peplau's suggestion that there is no place for information about the nurse's personal life in the nurse–patient relationship, the nurses in this study chose to talk about their Immediate family, Interests and activities, Life experiences and Identity with patients in mental health care (Peplau, 1997). The next sections will shed light on the reasons why the nurses chose to self-disclose.

6.2 | A number of reasons

Self-disclosure is listed as a communication technique and an example of nurses' use of self in mental health nursing (Stuart, 2008). A selection from the last four decades of the literature and research on self-disclosure provides a plethora of categories describing the reasons for goals, effects or functions of self-disclosure. In summary, these are the following: building therapeutic alliance, encouraging patient self-disclosure, increasing perceived similarity, modelling coping strategies, normalising patients' experiences, equalising power, conveying understanding and responding to disclosure requests (Arroll & Allen, 2015; Ashmore & Banks, 2002; Audet & Everall, 2010; Auvil & Silver, 1984; Coolidge Young, 1988; Deering, 1999; Henretty & Levitt, 2010; Henretty et al., 2014; Hill & Knox, 2002; Knox, Hess, Petersen, & Hill, 1997; Levitt et al., 2016; McCarthy Veach, 2011). Although these categories can be identified within the themes of this study, the nurses' descriptions illustrated that reasons to self-disclose are multifaceted and that one particular self-disclosure can be motivated by more than one reason at the same time. The first subtheme, "Sharing existential and everyday sentiments," can contribute to increasing perceived similarity, normalising patients'

experiences and conveying understanding. The second subtheme, “Giving real-life advice,” can be an example of the aforementioned categories, but also of how nurses model coping strategies through self-disclosure. And all of these can come about as responses to patients’ disclosure requests—that is, the fourth subtheme, “Answering patients’ questions.” These examples are not exhaustive, but illustrate complex reasoning behind nurse self-disclosures.

6.3 | A setting for self-disclosure

The third subtheme, “Feeling natural,” is not covered by previous findings. The importance of case-by-case consideration and sensitivity to context in deliberating self-disclosure has been mentioned by other studies, but critics have pointed out that situational and contextual variables have not been sufficiently considered (Arroll & Allen, 2015; Audet & Everall, 2010; Auvil & Silver, 1984; Barnett, 2011; Gibson, 2012; Henretty & Levitt, 2010; Levitt et al., 2016; Ljungberg, Denhov, & Topor, 2017; Peterson, 2002; Pinto-Coelho et al., 2016). Seeing that a considerable amount of research on self-disclosure has been limited to individual therapy settings, findings are not necessarily entirely transferable to other healthcare settings. The emphasis the nurses in this study placed on how self-disclosures feel natural in certain situations suggests that there can be different norms for self-disclosure in a mental healthcare setting.

Treatment philosophies can influence nursing practice by setting the standards for care, and recovery-oriented practices are central to contemporary mental health nursing (Leamy et al., 2011). In recovery, there is focus on a holistic approach, empowerment and care being individualised and person-centred (Stuart, 2008). In a person-centred approach, there is a need for the professional to be present as a person (Rogers, 1995). This means that nurses should refrain from putting up a front or façade and be themselves genuinely and transparently (Jourard, 1971; Rogers & Stevens, 1967). The nurses valued genuineness, describing it as honesty and openness, and nondisclosure did not seem to feel as natural as self-disclosure did. The natural feel of self-disclosure could be an expression of how nurse–patient relationships are genuinely experienced as human-to-human relationships where nurses do not objectify either themselves or their patients, but relate to one another as subjects (Buber, 2013; Hummelvoll, 1996). This could threaten a nurse’s focus on the patient and the patient’s best interests if the nurse’s self-disclosures are too frequent, too intimate or otherwise inappropriate.

The care settings in which mental health nursing takes place can also influence whether self-disclosure feels natural. Even though the care settings included in this study represented different treatment contexts, the nurses felt self-disclosures were natural across settings. This could be linked to the nurse’s role and the need for building therapeutic relationships no matter the care setting (Stuart, 2008). It can also be viewed in the light of the informal interactions that take place in a mental healthcare setting. Nurses and patients engage in many everyday life situations, such as sharing meals, going for walks or simply spending time together, talking. Informal interaction situations provide opportunities for authentic interaction and reciprocity, which self-disclosure can be a part of and can be important to patients’ therapeutic processes of change (Skatvedt & Schou, 2010).

6.4 | The six rights of therapeutic nurse self-disclosure

The different reasons for nurse self-disclosure are united by their potential to transform the nurse–patient relationship. Self-disclosure can alleviate a patient’s need for closeness and friendliness that other studies have found to be lacking in the nurse–patient relationship (Donati, 2000; Müller & Poggenpoel, 1996). Self-disclosure holds promise for making a relationship more open, honest, close, reciprocal and equal. The benefits of nurse self-disclosure are not a given, but contingent upon case-by-case consideration. When nurses administer medication, they follow specific rights to ensure safety and quality of care, and this practice could be transferred to self-disclosure. The rights include rights such as right patient, right drug, right time, right dose, right action and right response (Elliott & Liu, 2010). If applied to self-disclosure deliberation, this could involve considering the patient’s diagnosis (right patient), self-disclosure content (right drug), situational context (right time), frequency and level of intimacy (right dose), reasons for self-disclosure (right action) and the patient’s response (right response). The therapeutic value of nurse self-disclosure could be determined by nurses’ conscientious deliberation of these rights.

6.5 | Limitations

All three authors are female nurses with mental healthcare experiences, which might have influenced the data interpretation. The first author was in direct contact with the participants, and some had prior knowledge of the first author through acquaintances, having been colleagues with one of the first author’s family members, or through the local community. Being an insider researcher can make you blind to some aspects of the research phenomenon, but it also has some advantages for example gaining access to the field. As the research settings were in a small town and rural villages, results might have limited transferability to urban settings. Self-disclosure in nurse–patient relationships does not necessarily depend on the larger context, although norms for disclosure can be part of the cultural context. The study was conducted within mental health nursing, but results could be relevant to other nursing specialities and care settings. The amount of data could be considered a limitation because it makes the research process very time-consuming, but source triangulation can strengthen the validity of the results. A clear definition of the term *self-disclosure* helped with navigating the data set. Unlike much of the other research on self-disclosure, this study is naturalistic, exploring self-disclosure where it occurs in clinical settings. Further research could describe in detail how the specifics of clinical settings influence self-disclosure.

7 | CONCLUSION

Nurse disclosure of personal information pertaining to Immediate family, Interests and activities, Life experiences and Identity to patients in mental health care is common among participants in this study. By sharing personal experiences and dispersing advice when it feels natural and is sometimes requested by patients, the nurses experience that they facilitate a more open, honest, close, reciprocal and equal relationship with patients. This transformation of the nurse–patient relationship is the main reason why the nurses chose to self-disclose. In addition, mental health nursing involves informal interaction situations that could contribute to explaining why nurses can experience self-disclosure as natural across different clinical settings.

8 | RELEVANCE TO CLINICAL PRACTICE

The controversy surrounding self-disclosure can make nurses unsure of whether they should share personal information or not. The results provide an insight into the diversity of and reasons behind nurse self-disclosure that can contribute to thorough deliberation and help nurses make conscientious disclosure choices in their relationships with patients in mental health care.

CONTRIBUTIONS

Study design: JVU, SV, MHH; data collection and analysis: JVU, SV, MHH and manuscript preparation: JVU, SV, MHH.

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