Social Workers’ Perceptions of Professional Boundaries within Residential Mental Health Treatment Settings

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the University Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.
Abstract

The beliefs about how to ethically treat those with mental illness have fluctuated considerably throughout the centuries in the United States. As a part of the community mental health movement, some mental health treatment is now provided in residential settings. The purpose of this study is to gain further understanding of social workers’ practice of professional boundaries within this specific mental health treatment modality. Using a qualitative design, six Licensed Independent Clinical Social Workers (LICSWs) employed within Minnesota Intensive Residential Treatment Services (IRTS) facilities were interviewed. Data were analyzed using inductive grounded theory and open coding which revealed the findings and suggested implications for future research and social work practice. The findings indicate that individuals’ understanding of the professional boundary concept is largely socially-constructed. Social workers in residential mental health treatment settings practice professional boundaries in three main ways: 1) informing clients of their professional versus personal role, 2) using limited self-disclosure, and 3) role modeling/teaching generalizable skills. In addition, the social workers described how their practice was influenced by the unique aspects of the treatment modality – providing 24-hour care for clients in a home-like setting. Finally, the data show that social workers believe a consensus in professional boundary practice among the IRTS facility staff is best practice, but this does not always occur due to staff’s differing professional roles and levels of experience. These findings indicate both the need for continued research as well as practical implications for social work practice – namely the importance of having frequent discussions about professional boundary practice within mental health treatment teams.
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Social Workers’ Perceptions of Professional Boundaries within Residential Mental Health Treatment Settings

For the past two centuries in the United States, the beliefs about how to ethically treat those with mental illness have fluctuated quite considerably. In the country’s infancy, those considered to be “emotionally deranged” (Karger & Stoesz, 2010, p. 339) were confined to overflowing local poorhouses or jails without care. The ethical emphasis was protecting the larger population from these individuals seen as dangerous. By the early 19th century and heavily influenced by Dorothea Dix, the ethical responsibility of care extended not only to the larger population, but to those with a mental illness as well. This was due to a changing view of the group – Dorothea Dix and others viewed this group as needing “moral treatment” (Karger & Stoesz, 2010, p. 339) rather than simply incarceration. Thus began a widespread advocacy movement for the rights of those with a mental illness (Karger & Stoesz, 2010; Ridgeway & Zipple, 1990). States began constructing large “asylums” (Ridgeway & Zipple, 1990, p. 11) and soon Congress passed legislation for “mental institutions” or “mental hospitals” (Karger & Stoesz, 1990, p. 339) to be built. This period known as institutionalization lasted for more than a century. Originally, these settings were intended to be short-term and treatment-oriented, but increased immigration and urbanization overwhelmed the facilities and shifted focus away from treatment to custodial care:

If one were admitted to an asylum and not discharged rapidly, the institution often became one’s “home,” providing for all basic needs, but creating “institutionalization” --a syndrome characterized by a loss of functional capacity, deviant behavior and values, and a mechanized existence. (Ridgeway & Zipple, 1990, p. 11)
Rather than emphasizing treatment to allow an individual to go out and resume activities of daily life, those with mental illness were cared for in a way that ended up fostering their dependence on the system (Ridgeway & Zipple, 1990). At this time, this was still considered morally ethical care.

The diminishing emphasis of moral treatment and growing institutionalization paved the way for another movement to take hold. The scientifically-minded reformers of the Progressive Era found what they thought was “a straightforward and surgically precise solution” (Karger & Stoesz, 2010, p. 339) to the inundation of “mental defectives” (p. 339) to state institutions. A part of the eugenics movement, doctors began conducting “compulsory sterilizations” (Kaelber, 2012) – performing medical procedures that sterilized patients without their consent. This was another shift in our nation’s consideration of ethical treatment of those with a mental illness. Eugenics and sterilization programs continued in varying degrees throughout the United States until after World War II, when they fell largely out of favor due to their ties to the genocidal policies of Nazi Germany. Despite this, some states continued to sterilize their residents into the 1970s (Kaelber, 2012).

Then beginning in the 1950s and reaching its height in the 1970s in response to this eugenics movement came a period known as deinstitutionalization (Ridgeway and Zipple, 1990). Responding to those calling for a reform of state mental health hospitals, Congress passed the Community Mental Health Centers Acts of 1963 and 1965 that aimed to eliminate state mental hospitals in favor of comprehensive community mental health services (Karger & Stoesz, 2010). Rather than being indefinitely confined to an institution, tens of thousands of people were discharged into the community to live in the “least restrictive environment” (Ridgeway & Zipple, 1990, p. 11). This concept of least
Restrictive environment became a new standard of ethical care for those with mental illness – these individuals could no longer be involuntarily hospitalized ethically unless considered to be dangerous to themselves or others (Karger & Stoesz, 2010).

Unfortunately the mental health system did not have a clear and widely accepted plan for how to handle this influx of those with a mental illness into the community as the new standard of ethical care was introduced. In order to accommodate the least restrictive setting guideline, a few models for residential services emerged early on and eventually the mental health system developed a “continuum” (Ridgeway & Zipple, 1990, p. 11) system of residential services that we still use today. In this continuum, several residential settings provide varying levels of service, supervision, and restrictiveness. The individual needing treatment moves through this continuum from a highly-restrictive, intensively staffed setting to subsequently less restrictive and staffed settings. Each setting functions to clinically stabilize the individuals and teach specific skills until functioning improves, in which time he or she is moved to a less restrictive setting. Despite this standard of care, exactly how this continuum model is implemented varies very much from mental health system to system, often by state (Ridgeway & Zipple, 1990).

Part of this discrepancy may be due to the lack of sharing between systems. For example, the U.S. Department of Health and Human Services’ (DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA) acknowledged that comprehensive information on their characteristics and numbers of residents in adult residential treatment facilities was quite limited. In response, SAMHSA commissioned a survey of all of the states in 2006 and received information from 34 states and the District of Columbia who provided information on 63 types of residential facilities. This survey
included information from 7,327 residential settings and a total of 103,393 beds on September 30, 2003 – the last time a survey like this has been conducted (Ireys, Achman, & Takyi, 2006). According to the Minnesota Department of Human Services (2013), Minnesota alone reported 54 residential facilities for adults with mental illnesses with a total capacity of 1,278 as of October 31, 2013.

Social workers have been a part of mental health system throughout the historical fluctuations of providing ethical treatment as summarized above. When social work was establishing itself as a consolidated profession in 1955, the newly-formed National Association of Social Work (NASW) adopted the mission to “enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (NASW, 2008, p. 1). All licensed professional social workers today agree to abide by the values, principles, and standards documented the NASW Code of Ethics when ethical issues arise. This document not only describes ethical responsibilities to clients, but extends also to colleagues, the social work profession itself, and the broader society (NASW, 2008).

Despite this, the document readily acknowledges that it does not prescribe specific rules for how social workers should act in all situations, such as working with those with a mental illness, for example. Instead, the document states that “specific application of the Code must take into account the context in which it is being considered and the possibility of conflicts among the Code’s values, principles, and standards” (NASW, 2008, pp. 2-3). This can pose some ambiguity for social workers’ conduct towards clients who work in mental health treatment, and in this case, those in residential mental health treatment facilities. In these settings, social workers often have co-workers
from other “behavioral sciences and related fields” (MN Statute 245.462, subd. 17) who have different ethical codes and standards of conduct.

Additionally, Brown and Wirak (2002) point out:

…as these community-based, individually tailored services have become a major service modality, staff face ethical issues not previously encountered in more traditional office-based services....Non-traditionally delivered services meant that the lines between staff behavior considered ‘professional’ and ‘unprofessional’ were often blurred. The nature of the relationship was more collaborative and less prescriptive. (pp. 23-24)

The purpose of this current study is to contribute to and extend the body of research on the ethical treatment of those with mental illnesses. In today’s world, maintaining appropriate professional boundaries with clients is one of the most widely-discussed topics regarding ethics in social work practice and mental health practice in general. This qualitative research study will attempt to close some of the gap in the literature regarding social workers’ perceptions and practice of professional boundaries in residential mental health treatment settings.

**Literature Review**

**Therapeutic Relationship**

In order to fully understand the concept of professional boundaries when working with clients regardless of the setting, we must turn our focus back to the beginning – the importance of the therapeutic relationship. Beginning in the early 20th century, Freud began writing explicitly on the impact of the relationship between client and therapist (Bachelor & Horvath, 1999; Horvath & Luborsky, 1994). As Horvath and Luborsky (1994) stated, Freud believed that “on the one hand, the clients ‘clothe the therapist with
authority,’...but on the other hand, they also need to feel that this power and authority is shared” (p. 568). He flushed out the concepts of transference, in which both the client and the therapist unconsciously link the other with significant figures from his or her past (Bachelor & Horvath, 1999; Mechanic, 1961). Carl Rogers continued to build upon this concept, by describing therapists’ qualities that would foster this relationship such as empathy, genuineness, and unconditional positive regard (Bachelor & Horvath, 1999).

Since these early conceptualizations, hundreds of research articles have been written about the impact of the therapeutic relationship. In 1999, Asay and Lambert (1999) published a meta-analysis of over 60 years of research that identified the therapeutic relationship as a curative factor – the relationship between the client and therapist/clinician accounts for 30% of success and change within clients. Outside of this, expectancy/placebo effects and the clinician’s utilized technique accounts for 15% each, while the final 40% is attributed to extratherapeutic factors – things that happen outside of therapy that clinicians have no influence over (Asay & Lambert, 1999). These four categories are known in the field as “common factors” (Drisko, 2004, p. 81) or “what works” in psychotherapy (Asay & Lambert, 1999, p. 23).

Although much research has identified the importance of this relationship between clinician and client, professionals have not reached a consensus on one definition of this concept, nor its fundamental components (Bachelor & Horvath, 1999). In the early 2000s, the American Psychological Association commissioned a task force to summarize a series of meta-analyses on empirically-supported therapy relationships (Norcross, 2010). The task force found “what works in general” (p. 118) within these relationships boiled down to 11 factors: empathy, alliance, cohesion, goal consensus and collaboration, positive regard, congruence/genuineness, feedback, repair of alliance
ruptures, self-disclosure, management of countertransference, and finally the quality of relational interpretations. Below, three specific topics will be discussed in more detail – the alliance, self-disclosure, and therapeutic use of self, which encompasses a number of the factors above.

**Therapeutic alliance.** This concept, also known as the *working alliance* or simply *the alliance*, is one that is often confused with the therapeutic relationship and even thought to mean the same thing. To be clear, the therapeutic alliance is only one part of the therapeutic relationship – a concept that is far broader and inclusive than the alliance. The beginning conceptualization of the therapeutic alliance also goes back to Freud, who defined it as the client’s positive transference onto therapist – the “glue” (Bachelor & Horvath, 1999, p. 136) that binds the client to the therapist. This original psychodynamic understanding did not suggest that the alliance in and of itself was therapeutic, which was reversed by Edward Bordin in the mid-1970s. He identified three essential components of the alliance: therapeutic goals, consensus on treatment tasks, and an interpersonal bond (Bachelor & Horvath, 1999; Norcross, 2010). Emphasizing collaboration and interactive elements of the relationship, Bordin asserted that the therapist’s development and maintenance of the alliance is, in itself, therapeutic.

Later contributors have enhanced Bordin’s work by emphasizing not only the alliance concept within therapeutic approaches, but also the client should be actively contributing to the treatment negotiation process (Hatcher, 2010). Today, clinicians have taken this information and adapted it to fit into their own theoretical frameworks, writing articles about the alliance as a part of psychodynamic perspective, interpersonal perspective, cognitive-behavioral therapy, humanistic psychotherapy, and the list goes on (Muran & Barber, 2010). In addition, research also has been conducted about how the
alliance can be fostered in different contexts, such as couples, family, and group therapy (Muran & Barber, 2010). Most clinicians have come to believe through research and their own experience that establishing a therapeutic alliance with a client is collaborative, purposeful work (Hatcher, 2010).

**Self-disclosure.** In direct conflict with the empirical evidence about the importance of collaboration within the treatment relationship, authors Bloomgarden and Mennuti (2009) assert that many still hold the belief that disclosure on the therapist’s part is inherently bad practice. They argue that almost every mental health treatment provider, regardless of educational background, has internalized some sort of an “obedience to Freud” (p. 6) and his notion of “therapeutic neutrality” (p. 7). They state that Freud’s famous metaphors—e.g. “like a mirror, reflect nothing but what is shown” and “like a surgeon, [we should be] focused and devoid of all human sympathy” (p. 6, as cited from Freud’s 1912/1936 *Therapy & Technique*)—have been interpreted rigidly, especially regarding the concept of self-disclosure. Bloomgarden and Mennuti (2009) contend that “we have falsely pitted ‘neutral’ therapists against self-disclosing, overemotional ones” (p. 7).

Because of this, the practice of self-disclosure has been a widely-debated and researched topic throughout the years. Today, many psychological theorists see self-disclosure as an intrinsic part of the therapeutic relationship that has value when executed with clinical wisdom and skill (Bloomgarden and Mennuti, 2009; Gibson, 2012; Norcross, 2002; Sweezy, 2005; Zur, Williams, Lehavot, & Knapp, 2009). The ethical discussion has shifted from “whether” (Sweezy, 2005, p. 82) to disclose to more of an emphasis on the “what” and the “how” (p. 82). Nearly all of the many mental health
treatment models have differing philosophies—including definitions and subsequent subtypes—on the subject.

One way in which the self-disclosure literature differs is in how broadly the concept is defined. For example, some interpret it very narrowly, in that self-disclosure is the “intentional disclosing of verbal information for the sake of having a therapeutic effect, often referred to in the literature as ‘intentional’ self-disclosure” (Bloomgarden and Mennuti, 2009, p. 8). Others have broken down and identified different subtypes: verbal and nonverbal (Raines, 1996); deliberate, unavoidable, and accidental (Zur et al., 2009); and facts, feeling, insight, strategy, reassurance/support, challenge, and immediacy (Knox & Hill, 2003), just to name just a few. Still others think about this concept in a much broader way, such as Zur et al. (2009) who simply defines self-disclosure as the therapist revealing personal rather than professional information (e.g. credentials, office policies, informed consent) to a client. As cited by Bloomgarden and Mennuti (2009), Stricker and Fischer (1990) may have used the most general definition: “the process by which the self is revealed” (p. 8).

Researchers such as Gibson (2012), Knight (2012a), Raines (1996), Sweezy (2005) and others have discussed in length how differing theoretical orientations view the what, how, and ethics behind self-disclosure. In an interesting article by Jeffrey and Austin (2007), the authors found no studies that compared self-disclosure practices across professions. In response, they randomly sampled 38 Marriage and Family Therapists (MFTs) and 35 Clinical Social Workers (CSWs) in New York state and found that CSWs are less likely to disclose personal information to clients than MFTs, although both disclose on similar topics when they do. The authors also found that the MFTs believed clinician self-disclosure enhances the therapeutic relationship more than CSWs did.
One of the most current pieces of literature on social workers’ attitudes toward self-disclosure was conducted by Knight (2012a) using a sample of 192 social workers from the Maryland chapter of the NASW. She found that 85% of the sample “infrequently” or “never” (p. 302) engaged in personal self-disclosures, but 60% reported that they “frequently” or “infrequently” (p. 302) discussed with their clients their thoughts and feelings about what the client had shared with them. She found that they generally displayed positive attitudes towards self-disclosure, but they did not always feel prepared by their education to engage in the practice nor did they feel comfortable seeking guidance from a supervisor and/or a colleague about the subject (Knight, 2012a).

**Therapeutic use of self.** This above discussion of the therapeutic relationship and most specifically self-disclosure leads to another concept central to social workers – the therapeutic use of self. Raines (1996) compared this profession to others, stating:

> Perhaps one of the differences between social work and the other therapeutic professions is the degree to which we meet people who have suffered malignant depravations and losses. It seems to me that only the provision of an authentic person will suffice. (p. 373)

Indeed, the concept of engaging in a “highly present and real relationship with the client” (Edwards & Bess, 1998, p. 92) has been central to the social work profession going back to the early social work theorists. Social work pioneer Helen Perlman included genuineness in her list of seven essential elements of the social work relationship, stating also that part of the relationship’s purpose is to offer oneself to the client (Edwards & Bess, 1998). Emanuel Tropp, another early social work educator, also described mutuality and openness as two essential components of a social worker’s relationship with a client (Edwards & Bess, 1998).
Over the years, the literature has reflected social workers’ struggle balancing therapeutic use of self with objective neutrality and increasing emphasis on acceptable techniques (Edwards & Bess, 1998). Aware that the use of self concept can be somewhat ambiguous, Dewane (2006) combined her 25 years of practice wisdom and a synthesis of the seminal works on the subject to propose five ways to define and describe use of self in social work practice – use of personality, belief system, relational dynamics, anxiety, and self-disclosure. She agreed with an earlier work by Edwards and Bess (1998) that the most effective and skilled clinicians “meld[s] the professional self of what one knows (training, knowledge, techniques) with the personal self of who one is (personality traits, belief systems, and life experience)” (Dewane, 2006, p. 543) into their practice.

Researchers argue that the ability to integrate these various parts of self into effective practice cannot be achieved without sufficient self-awareness on the part of the clinician (Dewane, 2006; Edwards & Bess, 1998; Forrest, 2010; Knight, 2012b; Reupert, 2007). Edwards and Bess (1998) found that this self-awareness could be fostered through the process of conducting an inventory of self, developing self-knowledge, and accepting risks to self. Some also assert that clinicians should also engage in their own personal psychotherapy to continue to facilitate a deeper understanding of themselves (Edwards & Bess, 1998; McTighe, 2011).

In addition to self-awareness development, authors like Knight (2012b) and McTighe (2011) described how social workers’ practice of therapeutic use of self could be enhanced through clinical supervision. In what is referred to as a parallel process—the parallel between the dynamics of supervision and other helping professions (Shulman, 2010)—the authors argue that the supervisor’s engagement in use of self with the supervisee in a way that mirrors the practice in work with clients facilitates the alliance
and promotes trust in the supervisor (Knight, 2012b; McTighe, 2011). Through modeling the vulnerability that comes with sharing feelings and the ability to listen non-judgmentally within the supervisory relationship, McTighe (2011) argues that “the supervisor is in a unique position to assist in the integration of the…clinician’s personal and professional identities, and the honing of the finest of therapeutic instruments—the supervisee’s very self” (p. 306).

**Professional Boundaries**

As described above, creating a collaborative alliance, engaging in self-disclosure, and integrating personal use of self into the relationship can have profound positive impacts on clients. However, to paraphrase Freud, any process which has great healing capacity naturally also has the power to hurt. When applied to this subject, clinicians have to walk an “elusive line” (Richmond and Padgett, 2004, p. 54) when engaging in a therapeutic relationship with a client. According to Dewane (2006), the “integration of personal self and technical self implies tension between being a regular person in a real relationship and being a disciplined, ‘non-judgmental’ professional” (p. 551). In order to do so, clinicians have developed rules of this professional relationship that distinguish it from other relationships. Known as professional boundaries, some of these rules are absolute such as items included in a written code of ethics, and others are more flexible and depend upon the context and the clinician’s therapeutic orientation (Glass, 2003; Gutheil & Brodsky, 2008; Knapp & Slattery, 2004; Richmond & Padgett, 2002; Zur, 2007). Gutheil and Brodsky (2008) define a boundary as “the edge of appropriate behavior at a given moment in the therapeutic relationship between a patient and a therapist, as governed by the therapeutic context and contract” (p. 18).
Boundary crossings versus boundary violations. Within this discussion of professional boundaries, much of the literature distinguishes between boundary crossings and boundary violations. Generally, researchers agree that a boundary crossing is when a clinician deviates from the strictest professional role (Glass, 2003; Gutheil & Brodsky, 2008; Knapp & Slattery, 2004; Richmond & Padgett, 2002; Zur, 2007). Some of the most common examples include a clinician’s self-disclosure, non-sexual touch, chance encounters outside the office, exchange of small gifts or greeting cards, etc. Glass (2003) asserts that these crossings can run the spectrum from helpful to neutral to somewhat harmful. In general, however, these crossings are seen as relatively benign, non-exploitative, and may even support or advance the therapeutic relationship (Gutheil & Brodsky, 2008).

Boundary violations differ from boundary crossings in that these behaviors are exploitative of and harmful to the client, often performed in the sole service of the clinician’s interests (Glass, 2003; Gutheil & Brodsky, 2008; Knapp & Slattery, 2004; Zur, 2007). Zur (2007) describes these violations as “crossing the line of decency and integrity” (p. 5) and a misuse of the clinician’s power. This might involve the clinician having a financial, social and/or sexual relationship with the client outside of the therapeutic context. Much of the literature on professional boundaries discusses a slippery slope process in which minor boundary crossings gradually move into more serious violations (Glass, 2003; Gutheil & Brodsky, 2008; Knapp & Slattery, 2004; Zur, 2007). As cited by Zur (2007), Gabbard (1994) describes this process as “the crossing of one boundary without obvious catastrophic results [making] it easier to cross the next boundary (p. 51). Knapp and Slattery (2004) provide an example of this slippery slope in which a clinician may engage in “gratuitous self-disclosure” (p. 554) in one session,
increase the frequency over subsequent sessions, and eventually initiate social or sexual contact outside of therapy.

**Nontraditional settings.** After a review of much of the literature, a common theme emerged – much of the literature on professional boundaries was discussed in the context of an outpatient psychotherapy setting. For clinicians practicing in community mental health – specifically within adult mental health residential treatment facilities – it is unclear whether this information generalizes. Knapp and Slattery (2004) assert that while most clients have a general schema about office-based psychotherapy, they argue that these clients may not have a similar understanding of other more nontraditional settings. Much of the authors’ work discusses the boundary dilemmas that arise when delivering services within the homes or “natural environments” (p. 553) of clients:

First, boundary crossings are more likely to occur when services are being delivered in clients’ homes or residences. Second,…[it] allows more opportunities for them to act out or challenge boundaries. Psychologists and their supervisees who are not experienced in working in nontraditional settings may be unprepared for these challenges. Finally,…[they] may be at a higher risk to drift away from a professional relationship. (p. 554)

In addition to these concerns, Brown and Wirak (2002) point out another difference in practice within a residential setting as opposed to an office-based psychotherapy setting in that staff inherently takes on multi-dimensional roles throughout the course of the day. In addition to providing one-on-one therapy, clinicians in these settings will likely eat a meal, engage in social conversation, administer medications, and help meet their basic needs, etc. with their clients. The authors argue that the relationship
between clinician and client in a residential treatment setting is fluid and is often filled with ambiguity.

Both Brown & Wirak (2002) and Knapp & Slattery (2004) agree that one way to combat these challenges within nontraditional settings is to establish very clear rules regarding professional boundaries. Rather than “constraining staff with bureaucratic procedures,” (Brown & Wirak, 2002, p. 37) the intention would be to “offer clear guidelines that provide focus and a sense of security” (p. 37) that would allow both the clients and staff to know what to expect. Knapp and Slattery (2004) assert that this can be accomplished through thorough, ongoing training that does not “just provide a list of ‘do’s’ and ‘don’ts,’ but…should explain the reasons for these rules,…how to apply them,…and encourage…to discuss any unclear situations” (p. 557).

**Social work role.** Compounding the difficulty of understanding the appropriate professional boundaries within a residential setting is that, inevitably, much of the staff has differing educational and professional backgrounds – each is operating from separate ethical codes. For example, the NASW’s *Code of Ethics* specifically prohibits social workers from engaging in dual or multiple relationships with former or current clients. The only exception to this is when these relationships are “unavoidable,” (p. 9) at which point the *Code* indicates that it is the social worker’s responsibility for setting “clear, appropriate, and culturally sensitive boundaries” (p. 9). In contrast, the American Psychological Association’s *Ethical Principles of Psychologists and Code of Conduct* state that multiple relationships are not unethical as long as they “would not reasonably be expected to cause impairment or risk exploitation or harm” (Zur, 2007, p. 228). The American Counseling Association’s *Code of Ethics* has yet another take on this subject, stating that “counselor-client nonprofessional relationships…should be avoided, except
when the interaction is potentially beneficial to the client” (Zur, 2007, p. 229). It goes on to inform counselors of how to proceed when engaging in a “potentially beneficial nonprofessional interaction” (Zur, 2007, p. 229) – namely documenting the rationale and anticipated consequences in the client’s case record. The above example only reveals three different stances on one boundary-related issue. It stands to reason that establishing clear rules regarding professional boundaries within residential settings may not be as cut and dry as indicated by some of the researchers.

**Research Questions**

A review of the literature shows that engaging clients in a therapeutic relationship that fosters a working alliance and incorporates appropriate self-disclosure and use of self on the part of the clinician is one of the most important factors in successfully treating their mental health issues. The research also indicates that within this therapeutic relationship, it is important for the clinician to use appropriate professional boundaries that do not result in harm or exploitation of their clients. Unfortunately, much of this research focuses on clinicians providing psychotherapy to clients in office-based settings, and does not address clinicians who work in more nontraditional settings such as adult residential treatment. An additional challenge for social workers practicing in these residential settings is that there is often a mix of staff from varying professional backgrounds whose codes of ethics may differ from one another. Given this gap of information, the current research questions for this proposed study are:

1. What do social workers' practice of professional boundaries look like with clients in a residential mental health treatment setting? What kinds of practices do social workers perceive to be boundary crossings and/or violations in residential mental health treatment facilities?
2. Do social workers perceive the practice of social work boundaries in a residential setting to differ from the practice in other mental health treatment settings (e.g. outpatient psychotherapy) in which they have worked previously?

3. Do other staff members in residential mental health treatment facilities view and practice similar boundaries to social workers? If not, how do social workers perceive this to affect both the clients and their practice?

**Methods**

**Research Design**

The purpose of this study is to explore social workers’ practice of professional boundaries when treating mentally ill clients in a residential setting. As such, the researcher used a qualitative and exploratory research design. As opposed to quantitative designs in which subjects are usually limited to a set of specific, predetermined responses, qualitative research allows the subject to respond to several open-ended questions. In addition, a qualitative design allows the study to be much more exploratory. The researcher is free to follow the interview subject’s lead—such as posing unscripted clarifying follow-up questions—in order to really investigate his or her ideas about the question posed. In the case of this research, social workers providing mental health treatment to clients in residential settings were the authorities by which greater understanding and exploration of the concept professional boundaries was obtained.

**Sample**

Participants for this research project were obtained through availability sampling. Every year, the Minnesota Department of Human Services’ (DHS) Division of Licensing provides lists of licensed facilities in the state. The researcher obtained the list of all adult mental health residential facilities – commonly referred to as Rule 36 facilities.
DHS categorizes all the licensed residential facilities into five different types: Category I (CI), Category II (CII), Crisis Stabilization Services (CSS), Intensive Residential Treatment Services (IRTS), and Eating Disorder Intensive Residential Treatment Services (EDIRTS). As the researcher resides in Hennepin County and the research institution is in Ramsey County, both of these counties were targeted for this research. According to the DHS list, the most prevalent type of residential facility in these two counties is, by a large margin, IRTS facilities. Hennepin County has nine licensed IRTS programs, while Ramsey County has five, for a total of 14 facilities.

In addition to grouping the facilities by county, the published DHS Facilities List provides the facility name, license holder, address, and phone number among other pieces of information. The researcher used the phone number provided to call each of the 14 facilities and asked to be referred to the clinical director or some such person that would be in a position to provide agency consent for interviewing employees (see Appendix A for an unsigned copy). Upon gaining this agency consent, the researcher asked to be referred to any Licensed Independent Clinical Social Workers (LICSWs) employed as a mental health professional within the facility.

According to a Minnesota Department of Human Services (2010) variance, all IRTS facilities must employ at least one mental health professional “who meets the requirements” (p. 31) – someone who holds a master’s degree in “one of the behavioral sciences or related fields with at least 4,000 hours of post-masters supervised experience in the delivery of clinical services in the treatment of mental illness” (MN Statute 245.462, subd. 17). The responsibilities of the mental health professional include completing individual treatment plans, functional and diagnostic assessments, providing clinical supervision to mental health practitioners and/or mental health rehabilitation
workers, and the general care of clients within the facility (Minnesota Department of Human Services, 2010). While this position could be filled by a psychiatric nurse, psychiatrist, psychologist, marriage and family therapist, or a clinical counselor, the researcher only recruited participation from LICSWs due to the focus of this study.

All 14 IRTS facilities in Hennepin and Ramsey Counties in Minnesota were contacted for participation in this research. Seven of the facilities did not meet the research criteria, having reported that they did not have a LICSW on staff. In addition, one facility declined to participate and another two failed to get agency approval in the time provided for a total of 10 facilities that were unable or unwilling to participate. The remaining four IRTS facilities provided consent, for a total of six participants, as the researcher interviewed two LICSWs at two of the IRTS facilities. All are female.

**Protection of Human Subjects**

After obtaining agency consent but before the social workers participated in any part of the research process, each was presented with a consent form approved by the University of St. Thomas Institutional Review Board (IRB) (see Appendix B for an unsigned copy). This form provided the potential subjects with several pieces of information, including the study’s description and purpose, procedures, risks and benefits of participation, confidentiality, voluntary nature, and the researcher’s contact information. Each subject indicated her agreement with the terms by signing the document. The terms included participation in an audio-recorded interview. The transcripts of the recordings were de-identified and the researcher used pseudonyms in this paper, as appropriate, to further protect the participant’s confidentiality. These records were completely destroyed upon completion of the research project.
Data Collection

After the subject read and signed the consent form, the researcher scheduled an interview. Once the date was set, the researcher emailed each participant a short questionnaire (see Appendix C for a blank copy) to be filled out and returned before meeting in person. This questionnaire allowed important demographic information to be collected before meeting, so time did not need to be spent on these items during the interview. The settings of the interviews were in a quiet, private place of the participant’s choosing – all six chose to be interviewed in an office within their IRTS facility. The researcher used a semi-structured interview format, in that the participants were asked both open-ended questions approved by the research committee and the IRB, as well as other follow-up questions appropriate to the subject’s response. These questions addressed social workers’ practice in a residential mental health treatment setting relating to professional boundaries. The six interviews ranged between 19 and 48.5 minutes depending on length of responses and follow-up questions for an average of 34 minutes.

Data Analysis Plan

This research is relatively exploratory due to the minimal amount of research on professional boundaries in residential settings. To match this, the data were analyzed using inductive grounded theory. The researcher used the audio recordings to transcribe each interview and then analyzed the transcripts for meaning first through coding specific words and moving into more general themes (Berg & Lune, 2012). Although the researcher has some knowledge about professional boundaries, the inductive process was utilized to keep the researcher open to new ideas rather than letting this previous understanding constrain the ability to find something new. All levels of data were systematically considered from the specific to the abstract – raw data, codes or categories
such as words/terms used by the respondents, themes, and relationship between themes. While coding, the researcher also engaged in the frequent practice of writing theoretical notes, or recording reflections about what is being learned from the data (Berg & Lune, 2012). This practice of open coding revealed the findings/results of this study, which were then examined for implications to social work research and practice.

**Findings**

This qualitative research study was conducted in order to investigate three topics:

1) social workers’ practice of professional boundaries in mental health treatment settings, including boundary crossings and/or violations,
2) differences in professional boundary practice in residential versus other mental health treatment settings,
3) consensus or discrepancy between staff members and subsequent impacts on clients and practice.

All of these research questions were addressed in the six interviews, so these were assigned as the research findings’ major themes. Within these major themes, various subthemes were also identified, such as the definition and practice of professional boundaries, boundary crossings and/or violations, client population served, treatment provided in clients’ home, cause of discrepant practice, and impact of consistent versus discrepant practice. See Table 1 for a complete list of themes and sub themes. Each will be described in further depth with excerpts from the six interviews.
Table 1

*Findings Organized: Themes and Subthemes*

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**Theme 1: Participant Demographics**

**Theme 2: Understanding/Practice of Professional Boundaries in Residential Settings**

Subtheme 2.1: Definition of professional boundaries.
- 2.1a) Description of role.
- 2.1b) Self-disclosure.
- 2.1c) Development of understanding.

Subtheme 2.2: Practice of professional boundaries.
- 2.2a) Inform clients of professional role.
- 2.2b) Personal self-disclosure.
- 2.2c) Role-modeling and generalizing skills.

Subtheme 2.3: Boundary crossings and violations.
- 2.3a) Interactions with clients.
- 2.3b) Interactions with staff.
- 2.3c) Importance of supervision and consultation.

**Theme 3: Differences in Boundaries as Compared to Other MH Treatment Settings**

Subtheme 3.1: Client population served.
- 3.1a) Borderline personality disorder.

Subtheme 3.2: Treatment provided in clients’ home.
- 3.2a) Opportunity to be more personal.
- 3.2b) Increased accessibility to mental health treatment providers.

**Theme 4: Consensus or Discrepancy in Boundary Practice among Residential Staff**

Subtheme 4.1: Cause of discrepancies in practice.
- 4.1a) Mental health versus other staff roles.
- 4.1b) Age and/or experience.

Subtheme 4.2: Impact of consensus and/or discrepancies.
- 4.2a) On clients.
- 4.2b) On professional practice.

*Note:* The font style used for each theme/subtheme above mirrors the corresponding font style used later in the text.
Participant Demographics

The titles of these six participants included three mental health therapists, two treatment directors, and one clinical supervisor. All were female. The length of time in this position ranged from two to 10 years for an average of 3.75 years. One participant had just obtained her LICSW in the past month, otherwise the other five had been practicing independently for a number of years. Outside their positions within IRTS facilities, all of the participants had a range of other experiences in the mental health field including work in crisis residences, case management, corrections, schools, with adolescents and geriatric populations, etc.

Understanding and Practice of Professional Boundaries in Residential Settings

As indicated previously, a gap in the literature has been identified around the practice of professional boundaries in residential mental health treatment settings. The first way to examine this topic was to gauge social workers’ understanding of professional boundaries. Second, the researcher sought to understand how the participants carry out this understanding in the practice of professional boundaries within the IRTS setting. Finally, the participants were asked to describe what they considered to be boundary crossings or violations in their practice. In analyzing the responses to these questions, a number of subthemes emerged as illustrated in-depth below.

Definition of professional boundaries. When asked to define the concept of professional boundaries, the participants did not describe it in the same ways. This mirrors the literature in that there is not one generally-accepted definition of this concept. Despite this, the responses revealed a couple of similarities, provided here as subthemes – description of role and self-disclosure. These findings suggest that staff role with the clients as a professional as well as the practice of self-disclosure contribute to the
participants’ understanding of professional boundaries. Finally, a third subtheme emerged from participants’ responses indicating that most believe they developed this understanding of professional boundaries through practice and experience rather than in other ways such as social work education and trainings.

**Description of role.** In response to this question, four participants described how their role and relationship was different from a personal, casual, friend relationship. Quotes from the transcripts that describe this subtheme include: “you’re sort of being hired and paid to complete a function, so the relationship is not mutual…a personal relationship is generally a little bit different – more reciprocity,” “you’re the professional, they’re the client, you know, you just don’t cross boundaries there,” “I provide a service to help people recover – I’m not their friend, I’m not their confidant, I’m someone who works with them,” and “it’s recognizing where I end and the other person begins, and recognizing what is appropriate to share as a professional knowing that we’re not friends with this person, it’s not someone that is a casual acquaintance.” For these participants, understanding of professional boundaries included understanding the role they play in their clients’ lives.

**Self-disclosure.** Three participants mentioned self-disclosure in their definition of professional boundaries: “I do believe, as a therapist, you gotta give them something about yourself….I always try to pull out something that we have in common with the client,” “Putting the client first – not a lot of self-disclosure. That being said, there is a time and place for self-disclosure,” and “How is what I’m saying or doing, whether that’s disclosing or not disclosing, how is that helpful to this client.” All of these responses describe a relatively narrow view of the concept, what Bloomgarden and Mennuti (2009) describe as “intentional self-disclosure” (p. 8). The participants appear to be conflicted
about whether more or less disclosure is appropriate, but this subtheme reflects that the concept is considered to be a part of the understanding of professional boundaries.

**Development of understanding.** When asked about how they came to this understanding of professional boundaries, three mentioned social work education, two the NASW Code of Ethics, three ongoing ethics trainings, and one through own research and teaching about the subject. In addition to these settings, five of the six specifically mentioned that understanding came through direct practice and experience, as evidenced by these quotes: “You kinda get more of a sense of standard practice in residential than you do in school,” “It’s experience – it’s all experience...I always get frustrated when I have to go attend that ethics class because it’s like, I get it, but obviously they have it cause not all social workers get it,” and

*Both kind of personal experience, you know, different professional experience – having gone through getting my MSW and messing up – lots of mistakes. Things that I would say and then I’d be like, “Ooh, that wasn’t quite right. That wasn’t the way that I wanted to do it.”*

Based on these responses, it appears as if the concept of professional boundaries is one that is largely socially-constructed. The findings suggest that each social worker interprets this concept based on based on her or his experience coupled with an understanding of the importance the social work profession places on having boundaries when working with clients.

**Practice of professional boundaries.** As mentioned before, once an understanding was obtained about how the participants understood the topic, more specific information could be collected about the specific practice of professional boundaries in the IRTS setting. For the most part, the responses about practice mirrored
their understanding of the concept, such as clarity of their role and use of self-disclosure. In addition, other themes emerged as the participants talked about their practice. These subthemes are described below with accompanying excerpts from the interview transcripts.

**Inform clients of professional role.** Much like the subtheme identified above, the participants describe that while in a residential setting, they practice professional boundaries by directly explaining their role to the clients, as evidenced by the following quotes: “I think being real specific about what my role is, what kids of expectations they can have of me and the staff, and just kind of explaining the difference between a personal relationship and the professional relationship,” “We kind of let them know ahead of time that we’re going to be working with you for 90 days maximum because we’re a 90-day program and then we always talk about referring them to other places,” and “You know, you just kinda set that boundary right away and explain your role and usually things are fine from there once you set that.” In this setting, it appears as if directly informing clients of their role is a common practice.

**Personal self-disclosure.** The participants described the practice of personal self-disclosure to be a part of their work – most described using it with caution, as evidenced by the following two quotes: “We don’t really necessarily talk about our own personal issues unless there’s a therapeutic relevance about it” and

> When clients do ask me questions...I have some certain things that I kind of maintain. I usually don’t talk about necessarily where I live, how old I am...they might ask whether I’m married or not. I’m willing to answer that question, but there’s a lot of things I don’t answer. If I want to disclose, I usually try to
disclose things where I make it so vague that it’s either not necessarily specifically about me.

On the other hand, one of the participants advocated for the practice of “giving something about yourself” stating that she is “okay with that” but she was “not sure how other therapists feel about that.” She went on to give specific examples of her personal self-disclosures with clients:

I may tell them I know I was kind of like, grumpy one day. So before I met with clients, I let them know, I said, “you know, I got a really bad night’s sleep last night, I’m very tired. So just a heads up – not myself today.” So a little disclosure here and there just to let them know, like, how I’m feeling for the day….I try to pull out something that we have in common with the client....So if I know that they like cats or dogs, I’ll be like “I have a cat, her name is Lucy.”...I don’t care if any of my clients know that I have a dog or a cat. I don’t care if they know I enjoy music and I like to go to live shows and I collect records. A lot of times if I find a client who’s into music, I’ll share that about myself, you know “I collect records.”

Although there is a bit of a discrepancy on how the participants use the personal self-disclosure, most agree that it is a part of their practice when considering professional boundaries. The respondents did not, however, directly address other types of self-disclosure described in the literature such as nonverbal, unavoidable, or accidental. This finding of the participants’ discrepant understanding of self-disclosure also mirrors the current literature – not all researchers view this concept in the same way either.

Role-modeling and generalizing skills. Another subtheme addressed by most of the participants was using therapeutic use of self to teach skills that clients can generalize
to real life outside the treatment setting. The following four quotes describe this finding:

“How do we have better boundaries in response [to our clients] or how do we show what’s appropriate,”

*Just the other day, I got called pretty awful names because I wouldn’t take this person out to buy cigarettes. And, you know, in teaching that person, in the real world, no one in their right mind is going to have you go into their car and take them when you ask that way.... I said “Well, why do you think that I said that I’m not gonna do that for you? Because you called me some pretty awful names and that’s not okay.” I think I say that a lot. “That’s not okay. That really made me feel-- it was kinda scary to hear you yell at me.” You know, just to let them know how it feels to be yelled at....So as much as we can model this and, you know, “That’s not okay to say that. That’s not appropriate. That’s not going to get your needs met in the real world.”

“Sometimes if there’s conflict, having just a staff presence is good, and so it’s good modeling and that kind of thing,” and

[We] encourage the peers to depend on each other, which is a big boundary thing...you’re gonna be living semi-independently someday – you’re not going to have staff around. So there’s a pretty firm boundary of we don’t get involved unless you’ve asked three peers to help you first.

As these quotes reveal, the participants’ understanding of professional boundaries did not prevent them from utilizing therapeutic use of self in their practice to help role model and teach skills to their clients.

**Boundary crossings and violations.** The third and final theme that described the participants’ understanding of professional boundaries related to their perceptions of
boundary crossings and/or violations in practice. Participants were asked to comment on boundaries found to be most difficult to maintain – either in themselves or staff they supervised. The intention was to gather examples in interactions with clients, but interestingly half of the participants instead talked about their practice with their co-workers. They also spoke about the importance of utilizing supervision or consultation to prevent boundary crossings or violations from occurring. The following quotes describe these subthemes.

**Interactions with clients.** Other than the following two quotes, the participants did not generally talk about difficulty they personally have had with boundaries. They talked about things that have occurred with other staff or in other settings that they considered to be unethical, such as giving clients hugs, borrowing money from a client, regularly visiting a client in the hospital during personal time, etc. Other than that, the two individuals commented on the boundaries they find it difficult to maintain: “It’s probably more difficult for me to accept personal limits in terms of how much time I’m spending with somebody” and “I know my personality, and I’m an extrovert – all capital letters...and so I’ve had to know that boundary about myself and, um, just to kinda shush and let them talk and make it about them during the session.”

**Interactions with staff.** An interesting an unexpected finding was participants’ descriptions of professional boundary concerns regarding relationships with their co-workers, specifically about the professional versus friendship role and use of personal self-disclosure. The following four quotes describe this theme:

1) I kinda think the staff to staff boundaries get a little bit more tricky...because that’s [sic] less clear. There’s less-specific expectation around that, so pretty much people’s off-work behavior generally is their off-work behavior and
doesn’t really impact the workplace but then people sort of share or bring their off-work behavior to work and then they kind of open themselves up to judgment or different things.

2) You know, I’m not invited to the happy hours anymore. I’m not friends with any of my co-workers on Facebook, I just, I can’t. I don’t feel comfortable doing that role anymore, so I kinda leave work at work and I have my friends and my family and my own life outside of here. And sometimes I kinda miss that, ‘ya know? I’m not included in their weekend get-togethers, and I hear them talking about it....When you get higher up the ladder, there’s less of that being appropriate.

3) In my supervisory life, that’s been difficult when people who are not necessarily the same in terms of the hierarchy get to be friends, then it becomes difficult to give people feedback because you feel too close to them or whatever. And that’s a big problem, I think.

4) I think that one struggle that staff have here is actually knowing how much to disclose with their supervisor...I mean, it could be staff feel like they have enough of a good relationship with each other that they don’t want to, you know, tattle-tale or narc on their co-worker.

**Importance of supervision and consultation.** Finally, in discussing the issue of boundary violations and/or crossings, another clear subtheme emerged – a number of the participants indicated the importance of supervision and consultation to prevent inappropriate interactions: “If you notice that other people are having poor boundaries, that would be a good thing to bring up to your supervisor;”
In our old organization, every year there’d be some absolutely catastrophic betrayal of clients, whether it’s borrowing money from— you know, it’s always something. You could teach from here until the cows come home and there’s always one person that doesn’t get it, chooses not to get it, has a client come and put up their storm windows, every manner of boundary violations, so no matter how you do it, you gotta really watch— make sure people understand,”

“Make sure they get really good supervision and that they’re able to sort of ask questions and to keep asking questions until it sort of makes sense,” and

If there’s something that doesn’t feel right, I’ve gotta get consultation and if I have any hesitation to do that, that to me is like a warning sign – if you’re not willing to share something with your supervisor or your colleague.

The participants acknowledged that the nature of the work offers opportunity for boundary crossings and/or violations with both clients and staff, but willingness to utilize supervision or consultation is one mediating factor to reduce unethical practice.

Differences in Boundaries as Compared to Other Mental Health Treatment Settings

**Client population served.** In describing how the participants’ beliefs about how residential is different from other mental health treatment settings, they described the type of clientele served as a “high-risk population” and sometimes considered to be “vulnerable adults”: “We deal with people that have acute psychiatric diagnoses and typically come straight from the hospital and not always are completely stable when they come here.” In addition, they stated that the clients have different levels of participation in the services: “I have clients who want to engage in more therapy-type stuff and are able to. Not all my clients are able to – some of them are minimally-engaged, others are more engaged.” Finally, the participants indicated that the clients served “not only have
severe, persistent mental illness, they’re also chemical dependent” and “have a trauma past – grew up in very hectic homes where they were neglected, sexually abused, emotionally abused.”

The participants indicated that the population served “puts our responsibility to a whole other level to kind of maintain those boundaries.” Some of the unique challenges in maintaining professional boundaries include the population’s tendency to misinterpret things, ask personal questions, need to meet with providers more often, etc. The following quote supports the subtheme of differences in practice in response to the unique needs of the residential client population:

*The clients we work with have severe and persistent mental health issues, so sometimes the boundaries are just a little-- you know sometimes, they don’t quite-- they might misinterpret things. Especially if they have schizophrenia or if they’re delusional, things like that.*

“I think in long-term care, they’re older and they kind of understand more and they’re less likely to ask any inappropriate questions, you know what I mean? Whereas if they’re in this setting sometimes they might be more apt to?” and

*Yes, there’s gonna be times where I need to meet with somebody more often, but we are intensive residential treatment and so that’s the nature of the clients that we serve. And so I don’t think that’s pushing any boundaries – that’s kind of meeting the client where they’re at. I mean, I have a [to-do] list this long at any given time and I think it’s meeting the clients that are more acute – meeting with them, kinda taking care of them.*

**Borderline personality disorder.** Of the various mental illnesses, the most frequently mentioned diagnosis other than psychosis was borderline personality disorder.
Participants described that practicing boundaries with these clients was particularly challenging. Below are a few of the quotes that illustrate this subtheme:

*I know our clients who have the borderline personality disorder, um, diagnosed with that, a lot of the staff feel very frustrated...A lot of heated feelings will come up like why isn’t this person getting kicked out or why we’ve decided to keep someone in the house.*

“I’m gonna admit, I feel sometimes, I can feel myself like “uuugggh” you know? I just got done meeting with this person [with borderline personality disorder] for an hour and now she wants to meet with me again,” and

...the clients that we get, about 80% of them have been specifically diagnosed with borderline personality disorder or PTSD. And many of them have trauma or might have personality disorder features beyond that 80%...who definitely push boundaries or push not only boundaries, like, about people’s personal lives, but also push boundaries in terms of if we have rules and guidelines...it’s sort of, how do you pin Mom and Dad against each other. That sort of scenario happens quite frequently.

The excerpts above show how the respondents perceived the practice of professional boundaries to be different in a residential treatment setting based on the client’s illness.

**Treatment provided in clients’ home.** Five of the six participants made direct reference to a definitive difference between residential and other mental health treatment settings – providing care 24-hours a day, seven days a week in a home-like environment:

“We kind of pride ourselves here by letting clients feel like this is their own home, this is their space,” “So when you’re working in residential, they’re here, they live here, and this is their space. This is their home,” and “A lot of times they see this as their home or
“at least their temporary home, and we’re just kind of a fixture in it.” Two participants described specific details about what this meant in their day-to-day work environment: “We see people in their PJs even if we don’t want to. We see people coming out of the bathroom, we see them when they’re sick and needy and throwing up” and “It can be different when your workplace is somebody’s home, where they’re getting dressed and taking showers and eating and doing sort of all the things that people do in their home at your workplace.”

**Opportunity to be more personal.** Given the nature of providing treatment in a home-like setting, three of the six participants indicated that this facilitated more opportunities for both staff and clients to be more personal with one another. The following quotes describe this subtheme: “I think the nature of being in their home…it just comes up more, you know, if somebody had bad hygiene, it’s just more apparent,” You’re probably not in therapy with someone talking to them about, you know why it’s important to take a shower....So given that you’re kind of addressing a lot of times some very personal things with people, you kinda have to be respectful, but also it’s clear that it’s a professional obligation. “If you’re working in community mental health and working in a mental health center or a clinic setting, you’re probably not eating lunch with your clients,” and Practicing boundaries here is different....[In other settings] the types of questions aren’t as personal as they tend to be here....It feels like “Oh, well, I’m talking about my kids so I wanna ask you about whether you have kids”...Since there is more time with people, there’s more of a that sense of like, okay, we’re involved more in their life and then they tend to ask more about our lives as well.
As seen above, the participants reported that they feel like the residential brings up personal issues that would be unlikely to come up in a psychotherapy mental health treatment setting.

**Increased accessibility to mental health treatment providers.** A final subtheme that emerged from the participants related to the continuous nature of care provided in the residential setting is that clients get more opportunities to interact with staff. This is reflected in the following quotes:

*I think that the fact of that they’re here, and I can lay eyes on them and they can lay eyes on me, um, maybe makes it a little more of a challenge as opposed if I was in an outpatient office or somebody could only communicate over the phone typically."

“**Boundaries are definitely different because we are available all day. You know, they don’t have to go somewhere to see us, so in that respect, we are more accessible,”** and

...because the thing about residential is that they all live here. When you’re running a private practice, so you’re in outpatient therapy, you meet with them for one hour and then they go home. So the clients [here] are constantly: “Is Betty available? Is Betty available? Is Betty available?“

Finally, this longer excerpt is worth including here, because it eloquently describes how boundary practice differs in a residential versus other mental health treatment settings:

*Another different thing being in a residential versus being in a kind of psychotherapy is...psychotherapy is very much one therapist, one client, you know, and the likelihood of triangulation splitting and all of the things that can happen is gonna be much less in that kind of individual one-on-one type of setting, whereas when you’re looking at being in a milieu you have not only your*
relationship with this person, but their relationship with other people, and your relationship with other people and their relationship with other staff and how all of those dynamics become so complex. Someone said recently, I thought they said “the difference between having a relationship with one person is something like, there’s you, and me, and our relationship, so that’s like three. And once you get to like five people, it becomes astronomical, it’s like thousands of different combinations that happen. And so if I’m going to share with this person, I’m not only sharing with that one person, but I’ve shared with probably every other client that they’re going to talk to.

Consensus or Discrepancy in Boundary Practice among Residential Staff

When asked, all six participants agreed that a consensus in practice of professional boundaries among all of the residential staff is ideal. When asked about whether or not they think the other staff practice boundaries in the same ways, three participants stated they thought there was currently a consensus, two thought that practice was discrepant, and one had a mixed reaction.

**Cause of discrepancies in practice.** Two of the main reasons cited for discrepancies were based on staff role and experience, as described below.

*Mental health versus other staff roles.* A common theme that emerged was the respondents describing differences in practices based on the staff members’ roles – that although all staff received the same ethics training upon hire, specifically nursing and the peer support specialist roles are a bit different than the mental health staff roles. The following quotes describe this theme: “I would say nurses tend to have a little bit different set of what boundaries are, and that’s what I’ve seen across multiple jobs that I’ve had… it doesn’t seem like they have the same kind of ethical code or understanding,”
We have a certified peer and her boundaries are real different, and then we have to-- I mean, just that role is different. So we’ve had to talk a lot about it and do a lot of considering and supervision around it.

“I think there’s some difference, but I think-- you know, depending on the role for instance, like if you’re a peer recovery specialist, your education and your experience is gonna be far different,” and

Not everyone’s gonna be in the same place. We have a peer specialist here that also brings out another kind of level of what her boundaries are even though she has her bachelor’s degree in social work and so she’s licensed and she’s an LSW but she’s also a peer specialist and so her trying to figure out her boundaries and navigate those differences.....I’m a peer, I’ve experienced what they’ve experienced in a lot of ways, I can talk about meds or what my experience or my addiction history, and yet, I’m supposed to have these social work boundaries and values and ethics and how do I navigate both of those and find the best place.

Age and/or experience. Another reason commonly cited regarding differences between staff members boundary practices had to do with the person’s amount of experience in the field and/or their age. Five of the six respondents discussed this subtheme, illustrated below:

1) I’m probably one of the older people [at the IRTS], so I have a different role...the boundaries when you’re almost 60 are really different than the boundaries when you’re almost 20 or 25....Just the other day I was doing an intake with a client who smirked. And I said “Did you just smirk at me?” And he said, “Yeah, I wanted to see if you were paying attention.” So I said “I was paying attention and you know, if I were you, I wouldn’t underestimate me.”
And, you know, I don’t think I would have said that when I was 25. So I get to say that now because I’m a lot older than that.

2) I’ve been here for like 10 years, so I mean sometimes you kind of look at things through a clinical lens and, I mean, you question your boundaries, but maybe there might be something that you wouldn’t normally do but the clinical presentation calls for it and you can sort of like clinically justify it? But I think that can be complicated and so I think that maybe the less experience someone has, the more advisable it is to just sort of be more clear cut about boundaries….I think it’s not a skill set you just have, like, when you’re 18…you don’t naturally have sort of that clinical understanding.

3) I would say other staff here don’t feel comfortable being as firm and setting those boundaries and giving that type of directive, um-- as comfortable as I feel about it. I think that just comes with time….You just get to this point where it’s like – it doesn’t faze you anymore and you’re comfortable in your role.

4) It’s about 11 years that I’ve been in this field and I think, yeah, when I was a lot younger, I probably didn’t know. Now that I’ve worked with hundreds of people, I’ve gotten a better sense not only of myself, but of what is gonna best help the client. And sometimes that takes a little bit more flexibility in boundaries, sometimes it doesn’t.

5) There were times where people would push boundaries and I just didn’t have that experience to know what to say and what not to say.
**Impact of consensus and/or discrepancies.** The participants all agreed that both consistent and discrepant practice could have impacts on clients as well as their own practice. These subthemes are described below.

**On clients.** An evident theme given by the participants’ responses was that inconsistency in boundary practice would cause the client’s confusion: “*They’re not getting a message from one person that something’s okay and from another it’s not*” and “*I think it gets to be like that this staff will do it, why won’t that staff do it?...And then I think they can get upset with staff.*” One staff member stated that she believed the inconsistency could actually cause harm, specifically regarding the ability to trust their providers: “*The clients are] probably not sure exactly what they’re going to get with any one person, and so how do they build trust if they don’t know what they’re going to expect.*”

On the other hand, the practitioners thought that consistency would be helpful because it would allow them to trust their providers so they could focus on their treatment: “*They kind of feel like “Okay, they’re the professionals and they’re here to help me. I’m here to work on my goals and to help myself too,”*” and

*I would hope that if we were more consistent that that would specifically help them to trust us as a program more and trust everyone and for them to understand better some of those, what’s appropriate behavior or socially inappropriate behavior. And so I hope that consistency would be even faster, better, at teaching skills.*

**On professional practice.** The participants thought about and addressed the next questions about how discrepancy and/or consensus impacts their practice in several different ways. One participant commented that she thought that staff “*are able to do*
better work” when the clients have a consistent understanding of the boundaries. Another participant said that if she heard about inconsistencies in practice or “anything that’s been inappropriate” by other staff, “immediately I got to my supervisor…it’s something that I’m addressing right away.” Another participant actually cautioned against too much consensus, thinking that it could cause complacency in practice:

It’s a small program – [the staff] probably know way too much about each other and...you can kind of assume we all feel the same about this just because we’ve been all doing things together for so long. But I think it is important to sort of ask questions about boundaries and continue to kind of re-examine things.

Finally, one participant shared her personal experience of upholding boundaries regarding enforcing rules with clients when other staff did not practice the same level of consistency:

So I’m a little bit more on the rule side, and so yes, I’ve seen where [the discrepancy amongst staff] has caused more conflict between myself and clients....I’ve just had lots of experiences recently where I feel like I’m caught with my pants around my ankles. Like, my pants are completely down and I’m like, I don’t know how to deal with this situation....A more minor thing would be if a staff member said to a client, “Oh, you know, it’s fine for you to be out and I give you permission to be out for like, eight hours today and that’s okay and that’s all great.” It’s hard to be the other staff member to say “Way-way-wait. You know, you gave them permission, but that’s not really what we do here, so...” Kind of trying to talk to [clients] and then to set those limits becomes a lot more difficult....I’m like “Whoa! How do I backpedal from that?” I feel kind of caught
off guard. And then I feel like I’m the jerk. Either I feel stupid or I feel like a jerk, and neither of those feel like a good place to be.

Discussion

As revealed in the preceding findings section, the six qualitative interviews of LICSWs working in residential mental health treatment settings generated quite a bit of information that can help close the gap in the previous literature. All of the research questions were thoroughly answered and a number of subthemes were revealed. First, the professional boundary concept was addressed by the participants in their description of the professional versus a personal relationship role as well as the function of self-disclosure within that relationship with clients. While the interviewees discussed social work education, the NASW Code of Ethics, and ongoing ethics trainings, the overwhelming response was that experience in the field taught them the most about how to practice professional boundaries in their work.

Next, the participants took the time to describe the specifics of their professional boundary practice with clients. For these individuals, they discussed the importance of being transparent and informing clients of their role, how they decided whether or not to use personal self-disclosure with clients, and their therapeutic use of self in order to role model and teach skills that the clients could generalize to life outside treatment. They also illustrated what they perceived to be boundary crossings and violations in their practice – both in relation to clients as well as their co-workers. A general theme emerged that they believed that utilizing supervision and consultation would help prevent both the frequency of these mistakes, as well as preventing the boundary crossings to evolve into more serious boundary violations.
In order to address the second research question, the participants all had a number of past work experiences in the social work field, so they could describe how they felt like the residential nature of the IRTS programs were different from other mental health settings. Their responses painted a vivid picture of the type of clients they served, specifically the challenges that those diagnosed with borderline personality disorder pose to the practice of professional boundaries. The biggest subtheme revealed by the participants was how the type of continuous care in a home-like setting impacts their boundary practices. They described how this type of setting fostered opportunities a typical psychotherapy setting would not offer, such as increased occasion to discuss more personal topics as well as increased accessibility to mental health staff members.

Finally, the participants answered the third research question by indicating that they believe that a consensus in professional boundaries is ideal both for its impact on the clients’ treatments as well as their own social work practice. A couple of subthemes emerged when discussing the cause of discrepant boundary practice in residential settings. The first was that the participants believed that some of the staff’s roles in the IRTS facilities were simply different, namely the mental health staff versus the other roles such as the nurse or peer support specialist. The second was that they all perceived a difference in boundary practice between younger, inexperienced staff and older staff who had more experience in the field. They thought that discrepant practice fosters confusion among clients about the rules and boundaries within the facilities. The findings concluded with varied description of how the participants perceived this to impact their own professional practice. In all, the interviews provided rich information to contribute to the existing literature.
Findings Fit with Previous Literature

A number of the findings from the six participants’ interviews directly relate to the previous research included in accompanying literature review. Although the therapeutic relationship and alliance are important concepts to consider when providing appropriate ethical behavior, they were not directly referenced enough to be included in this study’s findings. Instead, several other concepts addressed in the literature were mirrored in this current study’s findings, including self-disclosure, therapeutic use of self, professional boundaries, boundary crossings and/or violations, and nontraditional settings. Below, each of these topics are addressed.

Self-disclosure. The participants made frequent references to appropriate self-disclosure when discussing their practice of professional boundaries. As indicated above, authors Bloomgarden and Mennuti (2009) assert that many clinicians still hold an internalized belief of Freud’s “therapeutic neutrality” (p. 7) – that personal disclosure to clients is inherently bad practice. The current findings seem to support this research, given that all but one participant described being cautious about using self-disclosure and limiting the use of the technique in their practice. In addition, the participants’ discussion of the topic seemed to center on the “what” and “how” of self-disclosure rather than the “whether” (p. 82) to disclose, just as Sweezy’s (2005) research suggests. Most of the self-disclosure practices described in the interviews were narrow in scope, defined as in the literature as “intentional” self-disclosure (Bloomgarden & Mennuti, 2009).

Therapeutic use of self. The social workers interviewed for this study described the importance of role-modeling and teaching skills to generalize outside of treatment, which can be seen as therapeutic use of self – a way to “offer oneself to the client” (Edwards & Bess, 1998). Dewane (2006) also considers self-disclosure to be a part of
this practice. Researchers have indicated that this practice can be effective with the development of self-awareness and effective clinical supervision (Dewane, 2006; Edwards & Bess, 1998; Forrest, 2010; Knight, 2012b; McTigue, 2011; Reupert, 2007), which was certainly a theme described by participants. One participant spoke a lot about self-awareness, while a number of others talked about taking advantage of clinical supervision being essential.

**Professional boundaries.** In addition to these more general concepts, the current findings also mirror a lot of the literature on professional boundaries. A common theme revealed by the participants is the discussion of personal versus professional role, which Dewane (2006) described as “the tension between being a regular person in a real relationship and being a disciplined, ‘non-judgmental’ professional” (p. 551). These social workers certainly described needing to explain and make it clear that they were not friends with the clients, but rather individuals paid to provide mental health treatment.

**Boundary crossings and/or violations.** The participants also agreed with the literature by describing boundary crossings as times when staff deviated from that prescribed role (Glass, 2003; Gutheil & Brodsky, 2008; Knapp & Slattery, 2004; Richmond & Padgett, 2002; Zur, 2007). They also provided some examples of what they believed to be boundary violations, which mirrored the literature to be behaviors harmful and exploitative to clients and often performed in the sole service of the clinician’s interests.

**Nontraditional settings.** Finally, the participants’ responses fit much of the literature regarding the practice of professional boundaries in nontraditional settings. Knapp and Slattery (2004) described how clients may have a general understanding of office-based psychotherapy, but perhaps not about other settings. The responses
indicated that this was certainly true of their clients in the IRTS facilities. In addition, many of the clinicians discussed the need to be clear and upfront about the nature of the program and their role starting right from the client’s intake. Knapp and Slattery (2004) also indicated that the nontraditional setting “allows more opportunities for [the clients] to act out or challenge boundaries” (p. 554), which was definitely a theme that was described by nearly all of the participants. The most common way clients challenged the boundaries, per the participants’ reports, was in asking staff questions about their personal life or beliefs. A few of these clinicians gave examples of the questions asked, and which ones they were comfortable answering and which they were not.

Brown and Wirak (2002) indicated that the relationship between the clinician and client is often fluid and filled with ambiguity, posing challenges for the clinician, which would be mediated by establishing clear rules. This fit with the current findings that a) all the IRTS facilities addressed agency ethics policies yearly, if not more often during staff meetings and/or supervision, and b) a consistent rather than discrepant boundary practice among the staff was preferable to all of the participants. These authors describe how the clarity would allow the clients to know what to expect, which the participants said they attempted to do and is instrumental to avoid the client’s confusion.

**Strengths and Limitations of Current Research**

One of the biggest strengths of this research was gathering more information to help begin closing the gap in the literature. Although the concept of professional boundaries has been researched extensively throughout the years, relatively little attention has been given to the topic as applied to residential settings. In addition, the exploratory, qualitative design of this research allowed for a depth of discussion about the topics, permitting the social workers to convey a wide range of thoughts and opinions.
The semi-structured nature of the interviews provided some organization, but also gave the researcher the freedom to follow unexpected leads and ideas.

Limitations of the study are primarily related to generalizability. Due to the availability sampling, only a relatively small number of social workers in two counties of Minnesota contributed to the research findings. How these results are applicable to other social workers across the country is unknown. Another limitation of the research is the fact that only LICSWs within the IRTS facilities were interviewed – not the other residential staff members nor the clients themselves. This limits the following research findings to the perceptions of the social workers, rather than a comprehensive understanding of professional boundaries from multiple parties’ points of view.

**Implications for Future Research**

The purpose of this study was to try and fill some of the gap in the literature about professional boundary practice among social workers in residential mental health treatment settings. Extensions of this research study should address the generalizability limitations described above. It would be beneficial to include both clients and other non-social work staff members within the residential setting in the sample. The sample size should be much larger and hopefully include participants from residential facilities from all over the country.

These findings also point out a couple of other areas of investigation. Of the six participants, only one thought that staff’s practice of boundaries was different depending on their professional background. She thought that while social workers and marriage and family therapists are “a little bit more open to thinking about systems,” counselors “have very much a mindset of individual...more of a psychotherapeutic one, kind of individual therapist with an individual client mindset.” The other six participants thought
that there was consistency between all the mental health professions’ practice of boundaries, despite Zur’s (2007) findings that each profession’s ethical codes address boundaries in a little bit different ways. It would be interesting to conduct research that would further address this subject – whether a clinician’s educational and professional backgrounds translate into different understandings and practice of professional boundaries. This could be addressed both more generally in mental health practice as well as specific to residential settings.

Another area of research that could be investigated relates to the finding the participants’ belief that experience and willingness to participate in supervision to be the most formative aspect in maintaining professional boundaries. This finding combined with Knight’s (2012a) literature describing that social workers do not always feel prepared by their education, nor feel comfortable seeking guidance from a supervisor and/or a colleague indicate a gap to be addressed by further study. It would be interesting to gain some understanding about the difference between the people that utilize supervision for the purpose of addressing professional boundary practice and those that do not. What leads some individuals to feel comfortable in seeking out guidance as opposed to others? Is it the individuals’ past experience in supervision, their personality, the supervisor’s personality, the setting, or a combination of all of these factors? A study could also be conducted with a number of staff members in a residential setting that have varying amounts of experience to understand more about how that experience in the field and/or the specific setting leads to more competent practice of professional boundaries.

Finally, more research should be conducted on residential mental health treatment staff regarding the practice of professional boundaries with each other. This was an unexpected finding from this research – a number of the participants described how
challenging it is to maintain professional boundaries with their co-workers. While they cautioned against utilizing personal self-disclosure with their clients, the responses indicated that this practice was not maintained with their co-workers. The participants described that staff often share what one called “off-work behavior,” blurring the boundaries between professional and personal. As this topic was not the focus of the current research, further research is warranted to really understand this phenomenon – specifically whether this is something unique to a residential setting, or if it arises in other mental health treatment settings as well. As seen here, this study was limited to the findings described above, and much other research needs to be conducted to really get a full understanding of how professional boundaries are practiced within a residential mental health treatment setting.

**Implications for Future Social Work Practice**

In addition to suggesting areas of future research, this qualitative study’s findings also gave a guide for future social work practice. The final question asked of all six participants was to give advice to a social worker new to working in a residential mental health treatment setting about the practice of professional boundaries. The responses revealed two themes – awareness of unique environment and use of supervision or consultation – that directly relate to social work practice.

**Awareness of unique environment.** First of all, the participants acknowledge that the residential environment warrants different practice of professional boundaries than other mental health treatment settings. They advised that staff should be aware that clients could overhear conversations at any time, as the facility is, in effect, their home. On the same token, staff should be aware of the information that other co-workers may learn about you. One participant described the unique environment: “you’re all in this
office...they’re really in your business all the time.” In essence, the residential treatment setting plays out almost like a family system – one needs to have constant awareness of how dynamics in one situation may affect another situations.

Use of supervision or consultation. The participants also described that social workers new to this in this unique mental health treatment setting should ask lots of questions to begin to understand the idiosyncrasies of professional boundaries in this setting. In addition to asking questions, a number of the participants described making frequent use of formal supervision with a supervisor or simply consulting with other staff members. One clinician cautioned: “don’t pretend you know what you’re doing when you don’t.” They tried to normalize mistakes, stating that it is “how you learn” and will facilitate the practice of “listen[ing] to your gut reaction.”

Frequent discussion of professional boundaries within mental health treatment teams. The findings reveal that practicing professional boundaries in a residential mental health setting are challenging and fraught with ambiguities. In fact, the very understanding of this term is socially constructed. I grew interested in this topic having worked in a residential facility in the past. I felt more comfortable having very firm boundaries between me, the clients, and my co-workers. New to the field, it felt like this was the way I could ensure that I did no harm. I rarely self-disclosed any personal information to the clients, nor did I socialize with my co-workers outside of the workplace. I became known by the clients as the strict, rule-following, mean staff. My co-workers and I got along, but they stopped trying to gossip with me and inviting me to happy hours after work. Given these experiences, I started this project with a unique perspective of professional boundaries in residential settings – all staff should be on the same page about professional boundaries and be consistent in practice with clients. The
I thought staff should be on was mine – that firm, consistent boundaries was the best practice for clients.

Contrast this view with my research advisor who stated that he tends to be on the other end of the spectrum. He indicated that he tends to use self-disclosure fairly often in his work with couples and families throughout the years. In fact, he does not even like the term boundaries but prefers to think of this concept as *relationship negotiations* in which he would take into account the client’s past history including any problems with relationships. He said he identified a lot with the participant who discussed her frequent use of self-disclosure in order to connect, build the therapeutic relationship, and role model skills that can generalize to life outside treatment. Both of our understandings of this concept have been socially constructed based on our personality and past experiences.

All that to say – what if my research chair and I were both practicing in a mental health treatment team like the participants in this study? These clinicians described how they were guided by their social work education, the NASW *Code of Ethics*, and other agency trainings about the policies and guidelines regarding professional boundaries. In practice, it is easy to assume that all social workers have the same views of this ethical concept because they presumably all received the same information and trainings. As described by one participant, this can cause some complacency in practice. She stated:

*I kinda think in residential, it's easy to be like, “Well, this is how we do something” though that's not the best practice, and then just sort of not question it, like “we do this because we do this – this is always how we’ve done it.”*

*Probably in other settings too, but I kinda think it can get more like that in residential.*
She went on to describe how she really liked to work with interns, because they often question the policies and procedures. She realized that she frequently did not have any other response than “Because. I don’t know, that’s just what we do.”

It seems like all of this information illuminates the importance of having frequent conversations within mental health treatment teams regarding boundary practice. This will give an opportunity for everyone on staff to describe their socially-constructed view of professional boundaries – from someone like me who was relatively unexperienced in the field who was afraid of doing harm and being construed as mean by the clients, to someone like my research chair who has had years of experience and success in incorporating techniques like frequent personal self-disclosures. These ongoing discussions could also ensure that teams have more intentional reasons for policies and boundary practices so when new interns ask questions, the response will be something other than because it is just how it has always been done.

Hopefully, these dialogues will ultimately build a more cohesive team that understands how each staff member views the concept of professional boundaries and has had some sort of input in the way that understanding informs policies and practices within the treatment setting. As indicated by this study’s findings, the clients will benefit from this shared understanding and consistency within the treatment team. With practices like these—unlike in times past where they were considered to be emotionally deranged, moral defectives worthy only of being confined to asylums—those with mental illnesses will be given ethical care that they deserve. Mental health treatment that upholds the inherent dignity and worth of every person, no matter the diagnosis.
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Appendix A

**Agency CONSENT FORM**

Researcher: Please provide your agency with the information about your project and have your agency contact complete this form.

Agency: Please read this form and ask any questions you may have before agreeing to allow this study to take place at your agency. Please keep a copy of this form for your records.

<table>
<thead>
<tr>
<th><strong>Project Name</strong></th>
<th>Social Workers' Perceptions of Professional Boundaries within Residential Mental Health Treatment Settings</th>
<th><strong>IRB Tracking Number</strong></th>
<th>542311-1</th>
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General Information Statement about the study:
This study involves social workers’ perceptions and practice of professional boundaries within a residential adult mental health treatment setting.

Your agency is invited to participate in this research.
The agency was selected as a host for this study because:
This agency is not selected as a host for the study, but is included because it is an Intensive Residential Treatment Services (IRTS) facility in Hennepin or Ramsey County that potentially employs social workers in the role of mental health professional / therapist.

Study is being conducted by: Carmen Tomaš
Research Advisor (if applicable): Lance T. Peterson, LICSW, Ph.D.
Department Affiliation: School of Social Work

**Background Information**
The purpose of the study is:
Social work educational programs provide training to their students regarding ethical client care, including the importance of professional boundaries. Much of the literature on this subject focuses on this ethical practice in psychotherapy settings. Unfortunately, this leaves a gap of information and resources for those clinicians providing treatment to clients outside of these settings. This study is designed to address the lack of literature specific to this topic – to explore how social workers understand and provide ethical practice to their clients through professional boundaries in a residential treatment facility.

**Procedures**
Study participants will be asked to do the following:
State specifically what the subjects will be doing, including if they will be performing any tasks. Include any information about assignment to study groups, length of time for participation, frequency of procedures, audio taping, etc.

1) Complete a brief pre-survey questionnaire to be emailed to the researcher before the scheduled interview. The questionnaire will include general demographic information such as years in the field, educational background, etc.
2) Participate in one 30- to 45-minute, audio-recorded interview with the researcher in a quiet, private area of his or her choice
3) Answer several open-ended questions related to the participant's experiences of providing mental health treatment in a residential setting
4) Consent to a transcription of the audio-recorded interview by the researcher
5) Allow quotes and themes from the interview to be included in the research paper

Risks and Benefits of being in the study

The risks involved for subjects participating in the study are:
The study has minimal risks. Subjects may feel uncomfortable revealing boundaries that he or she have found to be most difficult to maintain in a residential setting.

The direct benefits the agency will receive for allowing the study are:
n/a

Compensation

Details of compensation (if and when disbursement will occur and conditions of compensation) include:
n/a

Confidentiality

The records of this study will be kept confidential. The types of records, who will have access to records and when they will be destroyed as a result of this study include:
The final published research paper will not include information that will make it possible to identify the participant or the agency in any way. The types of records I will create include a recording, a transcript, and a master list. When transcribing the interview, I will replace both the subject and agency's names with pseudonyms to use throughout the research paper. I will create a single master list in order to keep track of which pseudonyms apply to which person and agency. The recordings will be stored on my password-protected personal computer only. The master list document itself will be password protected and will only be stored on my secure computer. The de-identified transcript documents will also be password protected and stored both on my secure computer or flash drive. No one other than me will have access to the recordings or master list. Only my chair, Lance T. Peterson and I will have access to the de-identified transcripts. All of the documents mentioned above will be destroyed upon submitting the final copy of the research paper at the end of May 2014.

Voluntary Nature
Allowing the study to be conducted at your agency is entirely voluntary. By agreeing to allow the study, you confirm that you understand the nature of the study and who the participants will be and their roles. You understand the study methods and that the researcher will not proceed with the study until receiving approval from the UST Institutional Review Board. If this study is intended to be published, you agree to that. You understand the risks and benefits to your organization.

Should you decide to withdraw, data collected about you will NOT be used in the study.

Contacts and Questions
You may contact any of the resources listed below with questions or concerns about the study.

<table>
<thead>
<tr>
<th>Researcher name</th>
<th>Carmen Tomaš</th>
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<td>Researcher email</td>
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<td>Researcher phone</td>
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<tr>
<td>Research Advisor name</td>
<td>Lance T. Peterson, LICSW, Ph.D.</td>
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<td>Research Advisor email</td>
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<td>Research Advisor phone</td>
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<tr>
<td>UST IRB Office</td>
<td>651.962.5341</td>
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Statement of Consent
I have read the above information. My questions have been answered to my satisfaction and I consent to allow the study to be conducted at the agency I represent. By checking the electronic signature box, I am stating that I understand what is being asked of me and I give my full consent.

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| Print Name of Agency | |
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<th>Signature of Researcher</th>
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| Print Name of Researcher | Carmen E. Tomaš |

*Electronic signatures certify that:

- The signatory agrees that he or she is aware of the polities on research involving participants of the University of St. Thomas and will safeguard the rights, dignity and privacy of all participants.

- The information provided in this form is true and accurate.

- The principal investigator will seek and obtain prior approval from the UST IRB office for any substantive modification in the proposal, including but not limited to changes in cooperating investigators/agencies as well as changes in procedures.

- Unexpected or otherwise significant adverse events in the course of this study which may affect the risks and benefits to participation will be reported in writing to the UST IRB office and to the subjects.

- The research will not be initiated and subjects cannot be recruited until final approval is granted.
I am conducting a study about social workers’ perceptions and practice of professional boundaries within a residential adult mental health treatment setting. I invite you to participate in this research. You were selected as a possible participant because you are a Licensed Independent Clinical Social Worker (LICSW) working at a Hennepin or Ramsey county Intensive Residential Treatment Services (IRTS) facility. Please read this form and ask any questions you may have before agreeing to participate.

This study is being conducted by Carmen E. Tomaš, chaired by Lance T. Peterson, in the University of St. Thomas School of Social Work.

Background Information:
Social work educational programs provide training to their students regarding ethical client care, including the importance of professional boundaries. Much of the literature on this subject focuses on this ethical practice in psychotherapy settings. Unfortunately, this leaves a gap of information and resources for those clinicians providing treatment to clients outside of these settings. This study is designed to address the lack of literature specific to this topic – to explore how social workers understand and provide ethical practice to their clients through professional boundaries in a residential treatment facility.

Procedures:
If you agree to be in this study, I will ask you to do the following things:
1) Complete a brief pre-survey questionnaire to be emailed to the researcher before the scheduled interview. The questionnaire will include general demographic information such as years in the field, educational background, etc.
2) Participate in one 30- to 45-minute, audio-recorded interview with the researcher in a quiet, private area of your choice
3) Answer several open-ended questions related to your experiences of providing mental health treatment in a residential setting
4) Consent to a transcription of the audio-recorded interview by the researcher
5) Allow quotes and themes from the interview to be included in the research paper

Risks and Benefits of Being in the Study:
The study has minimal risks. You may feel uncomfortable revealing potentially negative aspects of your agency’s work environment and/or boundaries have you found to be most difficult to maintain. Please know, however, that the information you share will be kept confidential (see below.) Also, you have the right at any time to skip a question or to stop and remove yourself
from the interview without consequence. You will not obtain any direct benefits from participating in this study.

Confidentiality:
The records of this study will be kept confidential. The final published research paper will not include information that will make it possible to identify the participant or the agency in any way. The types of records I will create include a recording, a transcript, and a master list. When transcribing the interview, I will replace both the subject and agency’s names with pseudonyms to use throughout the research paper. I will create a single master list to keep track of which pseudonyms apply to which person and agency. The recordings will be stored on my password-protected personal computer only. The master list document itself will be password protected and will only be stored on my secure computer. The de-identified transcript documents will also be password protected and stored both on my secure computer or flash drive. No one other than me will have access to the recordings or master list. Only my chair, Lance T. Peterson and I will have access to the de-identified transcripts. All of the documents mentioned above will be destroyed upon submitting the final copy of the research paper at the end of May 2014.

Voluntary Nature of the Study:
Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas or St. Catherine University. If you decide to participate, you may choose not to answer any questions I ask. You are also free to withdraw from the study at any time.

Contacts and Questions
My name is Carmen E. Tomaš. You may ask any questions you have now. If you have questions later, you may contact me. You may also contact my chair, Lance T. Peterson. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:
I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study, which includes allowing the researcher to audio-record my interview. I am at least 18 years of age.

__________________________  _______________________
Signature of Study Participant                          Date

__________________________
Printed Name of Study Participant

__________________________  _______________________
Signature of Researcher                          Date
Appendix C

Pre-Interview Questionnaire

Please answer the following demographic background questions below prior to your scheduled interview with the researcher. Doing so will ensure that your time will not need to be spent on answering these questions. When completed, please email this form back to Carmen Tomaš.

Name:

IRTS facility:

Job title, roles, and responsibilities:

To clients:

To staff providing direct client care:

Length of time holding this current position:

Additional positions held at this facility and length of time, if applicable:

Educational background:

Specialization, if applicable:

Internships:

Previous work experience in the social work field, including a brief description of responsibilities and duties of each position:
Appendix D

Schedule of Interview Questions

1. In order to link the pre-interview questionnaire you submitted to the discussion we’re having together today, could you please expand on your role and responsibilities as the clinical supervisor at the IRTS facility by describing your typical work day?
   a) More specifically, what kind of interactions do you have with clients during the day?

2. Given this information, in what ways do you practice professional boundaries with the clients at the IRTS facility? Please try to give specific examples.

3. To go back a little bit, how would you define the concept of “professional boundaries?”
   a) How did you come to this understanding of this concept? Educational program? On-the-job training and/or experience?

4. Is the way that you practice boundaries with the clients in this setting different than the boundaries you practiced in previous work experiences?
   a) If yes, how is it different to past settings?
   b) If no, how is it similar to past settings?

5. Do you perceive that the other IRTS staff members you work with practice boundaries with clients in the same way as you?
   a) If yes, please describe the consensus in practice.
   b) If no, please describe how their practice with clients differs from yours.
   c) How do you think this consensus / discrepancy effects the clients?
   d) How do you think this consensus / discrepancy impact your practice?

6. Does your IRTS facility have specific policies around professional boundaries with clients?
   a) If yes, how are these policies communicated to staff?
   b) If yes, do you perceive these policies to be in line with the NASW Code of Ethics?
   c) If no, why do you think there aren’t any policies?
      If no, do you think it would be beneficial to have official policies about this subject? If so, why?

7. In your role as both a supervisor and clinician in this residential setting, what boundaries have you found to be most difficult to maintain; i.e. what boundaries have you been most tempted to cross or violate?

8. Finally, if you could advise a social worker who has never worked in residential mental health treatment, what advice would you give her or him about professional boundaries with clients in this setting?