

HOW CLINICAL NURSING INSTRUCTORS DEFINE AND CONSTRUCT
INTERPERSONAL BOUNDARIES WITH THEIR STUDENTS

by

MARK RICHARD PIJL ZIEBER
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Department of Nursing

The University of British Columbia
Vancouver, Canada

Date April 27, 1999

Abstract

The purpose of this study was to examine how nursing instructors define and construct interpersonal boundaries with the students they teach. While the last two decades have seen a transition in the philosophy of teaching and learning in nursing, boundary construction within the new direction has not yet been fully examined. The literature reflects a wide variety of opinions on what constitutes an interpersonal boundary in the context of a teaching practice. Data collection involved open-ended interviews with eight nursing instructors. The data were analyzed from the perspective of naturalistic inquiry and utilized a constant comparative technique. The study found that interpersonal boundaries were defined as limitations in the relational dynamics between the instructor and student. The construction of boundaries was a process that involved a series of boundary crossings between the delineation of professional and personal. The process of boundary crossing was enacted in the level of connection between the clinical participants and the amount and depth of self disclosure.

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Chapter 1: Background to the Problem

Interpersonal Boundaries

Clinical nursing is a relationally intensive process. Instructors and students work closely together and often face emotionally charged situations. An important component in the instructor-student relationship is how interpersonal boundaries between clinical participants are defined and constructed. The discussion of interpersonal boundaries stems from many of the changes that have been occurring in the philosophy and pedagogy of nursing education.

Since the 1980's there has been a concerted desire from nursing educators to change the prevalent educational model that is based upon the completion of objectives and a demonstration of required behaviors (Grams, Kosowski, & Wilson, 1997; Symonds, 1990; Watson, 1989). This educational model promotes a defined hierarchy in which the instructor holds a position of power and defines the process and content of the learning experience for the student. The model for interaction is one in which instructors maintain a regulated distance between themselves and their students (Gaines & Baldwin, 1996). This relationship enables the instructor to function as an evaluator of objective performance (Paterson & Crawford, 1994). This has typically been referred to as the behaviorist model of nursing education (Bevis, 1989).

A more recent trend in nursing education promotes a philosophy of education that requires a greater connection and partnership between the instructor and students (Murray, 1989; Gaines & Baldwin, 1996). Gaines and Baldwin (1996) related that in the past the relationship between the instructor and students was one in which students were dominated by and subservient to their instructor. The authors advocated the creation of a

connected learning environment in which both instructors and students were free to share life experiences. This idea of connected learning puts forth the notion that both instructors and students are in a process of learning. In such an environment instructors become models or mentors with a more personal relationship with students (Watson, 1989; Downey, 1993).

Though much of the recent nursing literature promotes the idea of connection, how this connection is defined and practiced remains vague. The literature fails to take into account how instructor and student interpersonal boundaries affect clinical interactions. This is an especially important consideration because of the growing trend in the literature which promotes a learning environment based on the ideas of caring and connection. As well, many modern nursing curricula promote the ideas of connection, partnership and co-learning (Lindsey & Shields, 1995). All of these concepts have a direct impact on the type of interactions that occur between the clinical participants.

This thesis explores how nursing instructors define and construct interpersonal boundaries between themselves and their students. The ensuing discussion will explore the definitions of personal and professional relationships, the place of self disclosure between instructors and students, the concept of connection, and the effects of boundary crossings.

Research Question

The research question is: How do clinical nursing instructors define and construct interpersonal boundaries with students?

Purpose

The purpose of this study was to examine clinical nursing instructors' perspectives of how interpersonal boundaries are defined and constructed in their teaching. The definition and understanding of interpersonal boundaries are important steps in examining the nature of the clinical relationship. If this is understood then instructors can create a better learning environment and teach more effectively.

Definitions

Connected learning environment: A learning environment in which an instructor and his or her and students interact in a manner that reflects a personal interest in each other's wellbeing.

Clinical relationship: The relationship between an instructor and one or more students.

Clinical participants: The instructor and one or more students.

Summary

The recent developments in nursing education necessitate an examination of the definition and construction of interpersonal boundaries between instructors and their students. The first examination will be in the literature pertaining to the topic.

Chapter 2: Review of the Literature

Introduction

This chapter will examine the literature addressing the concept of boundaries and the related topics of professional and personal relationships, connection and self disclosure. The concept of boundaries will be examined as it appears in both nursing literature as well as allied health and psychology literature. First, boundaries will be considered in the general literature and then as applied in the clinical nursing education context. Next, some of the philosophies of teaching influencing boundaries, such as caring and partnership, will be explored. Following this, the related topics of self disclosure, partnership, professional and personal relationships, and sexual misconduct will be dealt with. The Cumulative Index of Nursing and Allied Health Literature (CINAHL) database was utilized to identify articles, although my most successful technique proved to be manual searches of relevant journals.

Boundaries

The use of the term 'boundary' was used in many disciplines. In a physical sense a boundary was something that indicated or fixed a limit or extent (Merriam-Webster, 1987). A boundary in this context referred to a geographic border or a tangible barrier such as a wall or mountain range. An interpersonal boundary involved both a physical and a psychological component. It shaped the interplay between physical proximity and psychological connection within human relationships (Scott, 1993; Ryder & Bartle, 1991; Bruhn, Levine & Levine, 1993). For the purpose of this study, the term boundary and boundaries referred to the interpersonal boundaries between people.

The literature on interpersonal boundaries acknowledged both physical and psychological realities that were combined (Guthiel & Gabbard, 1993; Ryder & Bartle, 1991; Scott, 1993). Both of these realities together created a better understanding of interpersonal relationships. The physical aspect of boundaries was referred to as a personal space boundary by Scott (1993) who related that people have a defined comfort zone for physical proximity with another person. This comfort zone allowed some people to have a close proximity while repelling others. The level of allowed proximity was influential in determining the level of interaction that occurred. In a psychological sense, boundaries promoted a sense of individuality and self-identity and identified ourselves as being cognitively distinct from others (Hermansson, 1997). Boundaries also became a reflection of our personality (Hartmann, 1997). The practical implication of boundaries manifested itself in the amount of influence or interaction we allowed others to have with us (Hoover, 1995).

The literature did not delineate a hard and fast rule regarding how interpersonal boundaries should be defined. The usual interpretation was that an individual's value system had a primary role in shaping the process of boundary definition (Bruhn, Levine & Levine, 1993). These authors described that people valued varying degrees of closeness or distance in their interactions with others. Situational factors such as familiarity, perceived threat and trust also greatly influenced the definition of interpersonal boundaries. For example, a person may feel comfortable relating intimate knowledge about herself to a close friend and may actually experience joy in that aspect of the relationship. If a stranger elicited the same knowledge, or if the disclosure occurred under

duress, the experience would likely cause fear and evasion. In the psychological context, physical proximity was not as important as the level of emotional connection.

Interpersonal boundaries were best represented by a combination of both physical and psychological connection, one often influencing the other (Ryder & Bartel, 1991). For example, if a person feels threatened, the usual response is to feel the need to be isolated emotionally. The logical conclusion is also that such a situation also would stimulate a desire to withdraw physically.

Opposing Views of Boundaries

In the literature there were two opposing ontological views of interpersonal boundaries. One view conceptualized a boundary as protecting, limiting and constraining how far a relationship will progress (Owen, 1997; Webb, 1997; National Council of State Boards of Nursing (NCSBN), 1996; Hoover, 1995; Guthiel & Gabbard, 1993; Milgrom, 1992). Within this perspective having well-defined boundaries was viewed as positive and necessary. Situations that deviated from the established rules became boundary violations and were considered to be negative (Kagle & Giebelhausen, 1994).

The opposing perspective defined boundaries as a hindrance to meaningful relationships and connection between the clinical participants (Hezekiah, 1993; Downey, 1993; Hedin, 1989; Gaines & Baldwin, 1996; Symonds, 1990; Higgins, 1996; Grams, Kosowski & Wilson, 1997). The perception that boundaries separated people was of greater concern than the potential of boundary violations. This perspective sought to minimize boundaries to allow people to relate together with fewer hindrances.

Boundaries in Clinical Nursing Education

From my observations and experience in clinical nursing education, the interactions between instructor and students are typically characterized by a close working relationship. The length of nursing shifts, the small size of clinical groups, as well as the intimate nature of nursing work places the instructor and students in close proximity. How the instructor defines interpersonal boundaries affects the relationship with students and the type of learning environment that is established (Tom, 1997).

In the past, relationships between instructors and students have typically been characterized by hierarchy and defined roles. A clinical teaching manual from 1960 described the clinical instructor as the “agent of clinical instruction” and as one who holds a “dominant” position over the students (Wiedenbach, 1960, p. 6). Students were viewed as being recipients of the instructor’s greater knowledge. Perspective such as this inspired the pedagogical changes brought about through the curriculum revolution which began in the 1980’s (Watson, 1989).

Much of the current philosophical literature regarding nursing education advocated an environment in which boundaries between instructors and students were less structured and less hierarchical. Hedin & Donovan (1989) upheld that relationships must be dialogical, characterized by power-sharing and empowering of the learner through affirmation, and concerned with relatedness and connection. Watson (1989) promoted the notion that instructors and students should be equal participants in the learning environment.

Research of the last two decades has indicated that nursing students highly value a caring and connected relationship with their instructors (Hanson & Smith, 1996; Dillon &

Stines, 1996). In several studies the instructor's ability to establish relationships with students was ranked higher than the instructor's professional competence (Brown, 1981; Knox, 1985). The one notable exception was the study by Benor & Leviyof (1997) which placed interpersonal ability as second to instructor competence. There was a consensus, however, that the interpersonal processes of the instructor-student relationship were important considerations for students.

The move to incorporate feminist pedagogical principles also influenced the process of nursing education. Hezekiah (1993) proposed that nursing education should promote an atmosphere of mutual respect, trust, community and shared leadership. This was to be accomplished through a learning environment in which the instructor and students were considered partners in learning. Hezekiah assumed that students would undertake a degree of authority and the instructor would more closely identify with the student group.

The Caring Philosophy

The caring philosophy originated in nursing education in the 1980's. This perspective was important to interpersonal boundaries because it proposed that instructors needed to create a caring and connected environment with their students (Watson, 1989; Grams, Kosowski & Wilson, 1997; Higgins, 1996; Beck, 1991; Appleton, 1990; Halldorsdottir, 1990). It was intended that students would learn through the creation of a "loving, caring, safe environment so that the discovery of knowledge can be shared between students and faculty" (Symonds, 1990, p.53). According to Watson (1989) and Beck (1991), students learned caring behaviors through the instructor's modeling of caring behaviors towards students and patients. The caring philosophy stated that

interpersonal boundaries must be opened to allow a closer level of interaction between the instructor and student.

Partnership

The notion of partnership arose in the literature regarding instructor-student interaction. Partnership was to be realized through a process of mutual goal-setting and mutual evaluative processes (Gaines & Baldwin, 1996). An important architect of this educational model was Paulo Friere (1970) who, in his landmark book, *Pedagogy of the Oppressed*, advocated that learners become active participants in their own learning and assume the responsibility for understanding the learning process. The aspiration of this philosophy was to free individuals, through enhanced knowledge, from the oppression Friere claimed typified the relationship between educators and students. The change in students' role from passive recipient to active participant changed the nature of their relationship with instructors.

The concept of partnership also implied a relationship in which students had decision making ability that was equal to the instructor's. Gaines & Baldwin (1996) related that many instructors had difficulty fulfilling this condition. Instructors had concerns that equal decision making ability would hamper the process of student evaluation. Another concern centered on the possibility of students putting patients at risk due to their relative inexperience and lack of nursing knowledge influencing their decision making processes. Instructors felt they had little choice but to make critical decisions based upon their own level of expertise rather than the desires of the student (Paterson, 1998). This decision contradicted the tenets of equality within the instructor-student relationship.

Self Disclosure and Boundaries

Self disclosure was defined as the act of revealing personal information about oneself to another (Collins & Miller, 1994). Self disclosure formed the basis for a relationship by providing both parties in the relationship with an understanding of each other (Derlega, Metts, Petronio & Margulis, 1993; Brown & Walker, 1990). Collins and Miller (1994) discussed the complexity of self disclosure and suggested that socially defined norms delimit when personal sharing is appropriate. In addition to providing an effective mechanism for enhancing relationships, they cautioned that self disclosure could also be destructive if it were inappropriate.

Gaines and Baldwin (1996) related that, in the past, nursing instructors wanted to know as much as possible about their students. Nursing students were typically expected to disclose personal information in conference time as well as in a personal journal. This expectation was rooted in the hope that student's disclosure would give the instructor a context for performance evaluation and tangible evidence of the student's learning (Wiedenbach, 1960). This need to evaluate forced the instructor into a position where she or he remained professionally distant and detached and did not self disclose (Rogers, 1996). The difficulty with remaining distant was addressed by Goldstein and Benassi (1994) who found that students participated more freely in an environment in which the instructors shared personal information and feelings. Derlega et al (1993) found that when instructors self disclosed to students an environment of trust and personal transformation was created. Self disclosure was considered to be a vital component of the connected relationship advocated by many authors (Grams, Kosowski, Wilson, 1997; Higgins, 1996; Beck, 1991; Appleton, 1990; Halldorsdottir, 1990).

Boundaries in Other Disciplines

The majority of the literature pertaining to interpersonal relationships in a professional context was found in counseling psychology and psychotherapy literature. These disciplines frequently introduced rigidly defined and well documented guidelines regarding what was considered appropriate in terms of interpersonal boundaries and what constituted a boundary violation. Counselors were expected to abide by "expectations of appropriate behavior" that were set forth by professional bodies and in relevant literature (Owen, 1997, p. 163). Most references to boundaries described protective mechanisms that separated a therapist from the personal realities of a client. Overall, the literature remained clear that the therapist had an imperative to remain a dispassionate observer and to maintain proper boundaries (Guthiel & Gabbard, 1993; Lazarus, 1994; Webb, 1997).

Not all writers in counseling psychology concurred with this view of separation. Brown (1994) described the tension that existed between her belief in a feminist philosophy of openness and connection and the traditionally prescribed boundaries in counseling therapy between the counselor and the client. She desired a relationship with her clients that allowed her the freedom to engage in a connected level of interaction. She felt that boundaries must be subject to the dynamics of the relationship rather than being defined in an arbitrary manner. This view was also held by Lazarus (1994), a leader in counseling psychology, who advocated that the effort to protect clients and therapists had resulted in an excess of caution and rigidity that dominated rather than guided the therapeutic relationship. Hermansson (1997) stated that "it should be recognized that the very nature of the counseling process demands a measure of boundary crossing" (p. 135). Hermansson saw boundary rigidity as a major hindrance to an empathetic relationship with

another person, advocating better management of interpersonal boundaries, rather than their removal.

Professional or Personal Relationships

One of the debates that entered the interpersonal boundaries issue centered on the difference between personal and professional relationships. When discussing boundaries in professional relationships Milgrom (1992) made a clear distinction between professional and personal relationships. A professional relationship, in his opinion, "is full of responsibility, time limited, requiring preparation, and having one person in charge" (p. 9). A personal relationship "is spontaneous, is not limited by time, involves equal power, requires little preparation, and involves a personal choice" (p. 9). Having distinct boundaries in professional relationships was viewed to "help prevent 'messes', the ones that are based in boundary ambiguities or caused by clear boundary violations" (Milgrom, 1992, p. 10). Milgrom's perspective was a good example of how professionals can create a distinct separation between the type of relationship present in a professional versus a personal context.

This view of a professional separation was also present in the education literature. Tauber (1998) advised that an instructor and her or his students could never be friends. He viewed friendship, the sharing of personal information and personal connection as a boundary violation that degraded the role of the instructor. He stated that "for instructors to lead, they have to maintain that professional aura. In the final analysis, that's what students themselves want and expect" (p. 2). This view was common throughout the literature pertaining to the broader educational context.

Boundary Issues and Sexual Misconduct

The issue of sexual harassment and exploitation was evident in the adult education literature addressing boundaries. The dangers of boundary violations involving sexual misconduct have been delineated by numerous authors (Pope, 1989; Barakat, 1997; DeCloedt, 1997; Pennsylvania School of Muscle Therapy, 1998; NCSBN, 1996). The NCSBN felt that self disclosure was the first step on a slippery slope leading to unethical relationships. The article cautioned that a behavior intended to create a connected learning environment might be misunderstood as a sexual advance. Pope (1989) reported a study involving adult women students in which 48% of the respondents reported some type of seduction attempt by an educator and 73% experienced some type of 'flirting' behavior. The presence of malicious intent was not established by the study but the women's perceptions of the instructor's behavior were of primary importance.

Summary

The clinical component of nursing education is in many ways a microcosm of nursing and the philosophies informing its evolution over time. With relationships becoming of greater importance in the clinical setting and literature content, the question arises of how interpersonal boundaries are defined and constructed. The former educational model that advocated a clear separation of professional and personal is being replaced with a framework that promotes higher degrees of instructor-student connection. Literature from various disciplines has shown that there are clear implications, both positive and negative, inherent in both perspectives.

I do not believe that the subject of boundaries has been examined adequately in nursing education. This is evident in the lack of nursing literature regarding boundaries

and interpersonal relationships, particularly as they relate to the clinical education context. Nursing education needs a clearer understanding of the implications of viewing boundaries as protective mechanisms and as hindrances to an effective relationship. The present study responded to the need to understand interpersonal boundaries in the context of instructor-student relationships.

Chapter 3: Methodology

Naturalistic Inquiry

The present study utilized a qualitative, naturalistic inquiry approach to explore and examine instructors' perspectives on interpersonal boundaries. A qualitative approach was best suited to the social and cognitive nature of interpersonal boundaries. Naturalistic inquiry looks at phenomena in the setting in which they occur and uses an inductive approach to data analysis (Lincoln and Guba, 1985). I chose this method because of a desire to explore the natural environment of clinical nursing instruction and the relationship between the principal participants, namely the instructor and students, from the perspective of the instructor. Data were gathered from instructors who were active in the setting of clinical instruction, in order to explore the dynamics of the instructor-student relationship.

Naturalistic inquiry allows the researcher to participate in the natural situation of a phenomenon and to construct theory inductively. Such an approach is an advantage in the realm of education in which human participants are in a constant state of change. Traditional qualitative inquiry assumes that truth is a concept that research can illuminate. A naturalistic inquiry approach allows an examination of a phenomenon while avoiding a critical evaluative process (Lincoln and Guba, 1985). This aspect of naturalistic inquiry was extremely important to this study. Instructors would undoubtedly resist participating in a study that evaluated their effectiveness as teachers. The naturalistic inquiry approach used in this study explored the phenomena of instructor-student interactions without imposing the researchers views of what constitutes effective interaction.

A phenomenological perspective was not chosen due to its inappropriateness to the research question. Phenomenology is a method that examines the lived experience of the participants and describes personal meaning (Burns and Grove, 1993). The research question was more concerned with how an instructor constructs the phenomena of boundaries rather than what the resulting boundary was. As well, a phenomenological approach would not allow for the review of literature before data collection (Boyd, 1993). The dichotomy of philosophical thought on what constitutes boundaries necessitated a review of the literature.

An ethnographic approach was also not consistent with the nature of the research question. Ethnography examines a behavior or way of life of a defined group of people (Germain, 1993). Such observations, while interesting, would not contribute the same richness of data regarding the definition and construction of theoretical boundary concepts in the instructor-student relationship. The purpose of this research was to explore the foundations of a relational process rather than to investigate the behaviors of a defined group.

The research question did not use a defined philosophical framework but instead adopted a series of ethical and methodological approaches that were consistent with the principles of naturalistic inquiry. The course of the research was allowed to emerge throughout the process of interviewing and analysis. The emergent aspect was essential to the concept of naturalistic inquiry (Lincoln and Guba, 1985).

Analysis

Data analysis was accomplished using a process of constant comparison. The data were analyzed and categorized into themes using an inductive path of letting the data

define the themes and determine the direction of the analysis. The study followed these steps from the naturalistic inquiry methodology (Lincoln & Guba, 1985): (a) "comparing incidents applicable to each category" (p. 340), coding the data into recurring themes based upon similarities and patterns; (b) "integration of categories and their properties" (p. 342), examining the foundation of the categories to see if the basic premise of the category was true to the data; (c) "delimiting the theory" (p. 343), reducing categories as they became saturated and as the construction of the phenomena become evident; and (d) presentation of the construction as a case study.

Rigor

In the present study naturalistic inquiry emphasized the maintenance of credibility and trustworthiness as expressions of rigor (Lincoln & Guba, 1985). My purpose was to provide a level of credibility to the design and outcomes of the research (Sandelowski, 1993). I used several techniques to ensure a level of rigor in my research.

I worked from the assumption that I already possessed a prolonged exposure to the natural environment of nursing education. I have been actively involved in clinical nursing instruction for the past six years. This exposure to the clinical nursing education environment increased the credibility of my study as I was inherently aware of the natural environment in nursing education (Lincoln & Guba, 1985).

I also utilized a process of peer reviewing (Lincoln & Guba, 1985). I submitted the inquiry to the review of a colleague, not associated with the research, who reviewed the process and was satisfied that both the conceptual basis of the study and the methodology were strong. She also found the results relevant to the substantive area of

nursing education. Her comments and feedback proved invaluable in both challenging and supporting the study

I structured the study in a manner that allowed the steps of the analysis to be clearly seen. Each level of analysis and refinement was delineated using colored highlighters and margin notes. My colleague who reviewed this study was impressed at the manner in which the analysis of the data allowed an audit trail. I considered this to be a strength of this study.

Lastly I created a reflective journal that captured my own thoughts and observations throughout the data collection and analysis process. The thesis process was an insightful and rewarding experience

Sample

I used a purposive sampling technique. This technique identified key informants that represented the phenomena being studied (Burns & Grove, 1993). Key informants were clinical nursing instructors who were active in clinical nursing education, preferably having taught for more than two years. The sampling process produced participants who were aware of the issues surrounding instructor-student interpersonal relations. A total of eight instructors participated in the study. The sample was largely homogenous with regards to ethnicity and educational preparation resulting in a richness and saturation of the data.

The sample included participants of both genders and represented a wide variety of experience levels between five years of teaching up to almost 30 years. Participants were recruited from two schools of nursing. This provided a broader perspective than what would originate within one school of nursing.

Initially, permission of the directors of both schools of nursing was elicited. Once permission was granted notices asking for participants were posted in conspicuous places at the institutions. One director invited me to do a short presentation of the study at a full faculty meeting. This proved to be a great resource that resulted in the recruitment of participants. As well, personal contacts at the institutes were approached to recommend qualified participants.

Ethical Considerations

The present study was approved by the UBC behavioral research ethics board. A high ethical standard for conduct and confidentiality was maintained throughout the study process.

Interview Process

Data collection was accomplished through interviews. The interviews were unstructured in nature and were held in a place that was agreeable to the participant. Most of the interviews occurred in the instructors' offices for the purposes of convenience, familiarity and quietness. The interviews were approximately one hour in length and were audio-taped to allow transcription. Trigger questions were used as catalysts for discussion but the progression of the interview was determined by the dynamics of the interactions between the instructor and myself as the interviewer. The instructors were allowed to control the subject of the discussion except in the case in which the discussion became needlessly tangential to the purpose of the study. There were, however, very few occurrences requiring the needed for redirection to the research question. In most situations, the participants talked about the subject of many of my trigger questions before I asked the question.

Data analysis began once the initial four interviews were completed and transcribed. The preliminary analysis of the first interviews influenced the direction of questions for the remaining interviews, as is characteristic of the constant comparative technique (Lincoln & Guba, 1985).

Data Analysis

The data were initially examined for key words that represented the concept of boundaries. From these key words, initial codes were written in the right hand margin of the transcripts. The initial codes consisted of verbatim phrases from the transcripts and phrases that represented the concept being discussed. These phrases or codes were analyzed to produce categories that represented all the data. The categories were organized by taking all of the codes relating to the particular category and grouping the codes by the eight different transcripts. This format allowed the viewing of all the category codes across all of the transcripts; thus, all of the data were accessible for analysis. Finally the individual categories were analyzed to look for emerging themes within the category.

Limitations

Absence of the Student Perspective

The major limitation of the study was the exclusion of the student perspective. Students are major stakeholders in the educational process in nursing and their perspective would add greatly to a better understanding of boundaries. Understanding students would be an essential component in completing the examination of instructor boundaries. This aspect had to be omitted to control the size of the study. I believe that student perspectives would be essential as a topic for future research.

Sampling Technique

The nature of this study and the sampling technique likely attracted instructors who had an interest in the conceptual understanding of boundaries in the clinical relationship and had effective methods of interacting and relating with students. Instructors who experienced difficulty in the instructor-student relationship or who had unethical relationships with students would likely not have wished to participate in a study that examined interpersonal boundaries.

Summary

Naturalistic inquiry was the best choice as the methodology for this study as the focus was on the natural environment of clinical nursing education. The process of analysis utilized the constant comparative technique. Rigor was maintained throughout the processes of exposure to the setting through peer review, the creation of an audit trail and the keeping of a reflective journal. The interview and analysis process produced data that were conceptually rich. These findings will be presented in the following chapter.

Chapter Four: Findings

Interpersonal Boundaries in the Clinical Situation

Note: For the purpose of the study and to maintain anonymity, the feminine pronouns 'she' and 'her' will be inclusive of both genders.

This chapter will present the findings of the study. The goal of this study was to describe how clinical nursing instructors define and construct interpersonal boundaries with students. An overview of the main concepts will be presented followed by a more detailed examination each concept. First, the concept of how instructors defined what constituted professional and personal boundaries will be examined. Next the concept of connection will be examined as well as the closely related topic of self disclosure. The role of time in boundaries will be explored following this segment. The next section examines the preconditions that instructors brought to their clinical teaching. These preconditions formed the foundational beliefs upon which the relationships with students were ultimately formed. Lastly, there will be an examination of boundaries and boundary crossings.

Overview

Boundaries were defined as mechanisms within the clinical relationship that limited the level of interaction, connection and self disclosure. How instructors constructed their boundaries was an enacted process that involved boundary delineations and crossings. An interpersonal boundary was not identified as one line but as a series of progressive delineations of what interactions were allowed at a particular time and for a specific purpose. Instructors related a process in which boundaries were crossed and re-crossed throughout the relationship. A boundary was crossed when an instructor allowed a

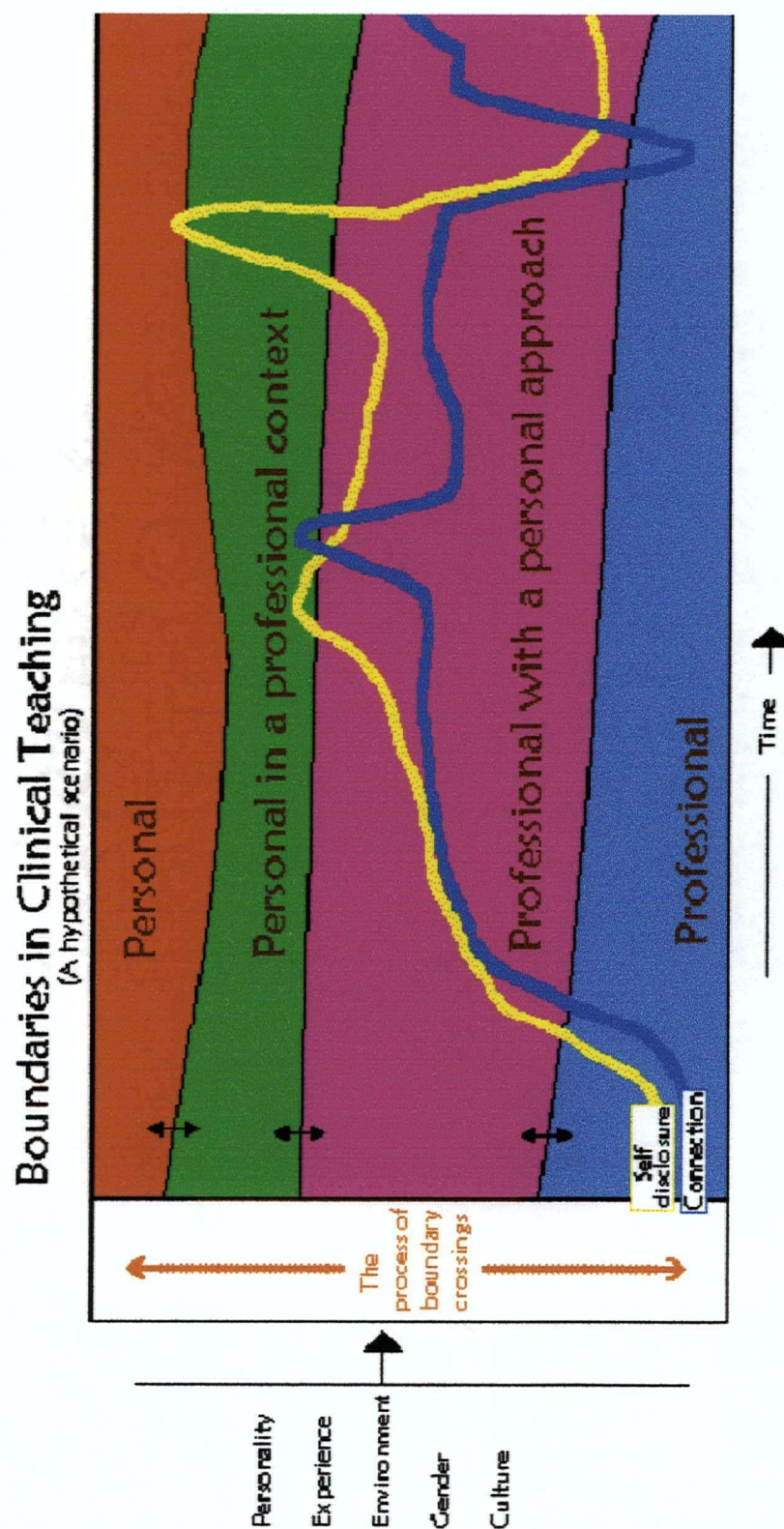
greater degree of connection than what presently existed. This process of boundary crossing began as an almost automatic process. As more boundaries were crossed, a point was reached at which the instructor did not allow a boundary to be crossed. This process of boundary crossings formed the basis for the interactions that occurred while instructing.

Though boundaries were the core topic of the study, several related themes were identified by instructors that influenced how boundaries were defined and constructed. The first theme was how instructors viewed the delineation of what was professional and personal as an important influencing factor in boundaries. Four levels were identified that represented a series of boundaries. These levels were identified as: (a) professional, (b) professional with a personal approach, (c) personal in a professional context, and (d) personal. These are presented in Figure 1. Each of these levels was representative of a group of boundary interactions that followed a particular pattern.

Connection was the second major theme to emerge. Connection was an indicator of how closely the instructor and student related and interacted together. In the study the level of connection started at a professional level and then progressed towards a more personal level of connection. This was not so with all instructors but was the typical pattern. Connection is represented in the conceptual diagram (Figure 1) as a fluid line that changes over time.

Closely related to connection was the theme of self disclosure. Self disclosure was the sharing of information about oneself and corresponded to the level of connection. If an instructor felt that there was a close level of connection, she felt more at ease to disclose more about herself. The main purpose of self disclosure was identified as a pedagogical technique to create a better learning environment for students.

Figure 1: Conceptual diagram



When an instructor started a clinical rotation, she carried preconditions that influenced how her relational boundaries were expressed. These preconditions were identified as the instructor's personality and experience, the environment of the teaching situation and the instructor's gender and culture beliefs. These preconditions were formed prior to the instructor meeting with the clinical group. They influenced the clinical relationship by forming the basis upon which the instructor enacted the boundary process with students.

Delineation of Professional and Personal in the Clinical Relationship

The delineation of professional and personal was primarily conceptualized as an expression of the relationship between the instructor and her students. All of the instructors related a desire to include both professional and personal interactions in their teaching. All instructors viewed themselves as pleasant people with whom it was easy to relate. Many saw how they were as a professional instructor to be a reflection of their personality. Instructors saw the development of a more personal relationship with students, especially in cases in which clinical rotations occurred over an extended period of time. Instructors stated that they let their boundaries "expand" or "evolve into a more personal exchange" over time. The feeling expressed by instructors was that there was a natural momentum that makes relationships move from professional towards personal.

A professional relationship consisted of interactions within the context of the occupation of the instructor. It involved both the activities of teaching and the relationships involved with work. The relationship was expressed as being time limited and subject to the higher purpose of educating nursing students. The concept of being professional was limited to activities intended to teach students the principles and lessons

of nursing. One instructor expressed it this way: "A strictly professional relationship is where you know each other...only in relation to your work and responsibilities...you don't have much of a chance to get to know each other as people". If an activity lacked the quality of contributing to the educational purpose, it was considered as belonging to the personal realm.

The separation of what constituted work life and home life was an important ingredient of the conceptualization of personal relationships. According to the instructors, personal relationships occurred outside of the professional setting and were usually within the context of a friendship or family relationship. One instructor stated that "with a friend or a family member, you'd get into [personal details], you confide in them and you know, it would be different".

Instructors related that they did not have friendships with students during the time of a clinical relationship. This was seen as an ethical conflict. Friendships with students sometimes occurred but not until after the clinical rotation and usually in the context of working together as RN's on the same nursing floor. One instructor shared that she "had never developed friendships with students at the time [of the clinical rotation]. Later students have become friends when we were working as colleagues".

The level of personal intimacy involved was important to how the instructors expressed what was personal. Instructors related that personal relationships involved "being able to disclose your vulnerabilities" and being "able to disclose your own inabilities". All instructors related certain personal occurrences that they did not share with a student such as "if I had a fight with my spouse" or "what a bad sleep I had last

night...or how awful I'm feeling or...that I burned dinner". Another instructor expressed it as "my personal life is not open for discussion".

Each instructor, when initially asked, was able to give a clearly defined opinion of what constituted a professional and personal relationship. The common expression amongst instructors was that the two relationships were distinctly separable in purpose and function and that there was value in remaining separate. As the interviews developed, however, contradictory statements began to occur that brought into question whether the instructors made a clear separation between professional or personal. Phrases such as a "personal professional incident" or "sharing personal stories" occurred indicating a blurring of the seemingly distinct line between professional and personal. The data revealed that the separation of professional from personal was not as easily delineated as was initially expressed by the instructors in the interviews. This seeming contradiction provided an essential insight into the nature of how professional and personal delineation related to boundaries. An overall examination of the data suggests that the relationship between professional and personal follows more of a series of levels defined by established boundaries.

Conceptualization of Professional and Personal

Instructors identified incidents that expressed differing levels of professional and personal interaction (see Figure 1). These levels were identified based upon the purpose of the interaction as well as the level of connection required. Instructors explained how they engaged in a process of assessing the level of interaction desired by students. Instructors identified various cues used in the assessment process. One cue was student responses to humor. If students "did not get jokes" or seemed bothered by the personal

nature of humor, then instructors related that they “backed off” from students. Another cue the instructors identified was the personal space boundary of a student. If a student expressed discomfort with the physical proximity of the instructor, then they backed away from the student and assumed a more professional level of interaction.

The level of interaction was accomplished through a process of observation. One instructor expressed it as “defining those rules all the time and watching how people define their roles with me, and keeping the professional and the personal separate”. Another instructor expressed it as a process of observing “just how the interaction will be between yourself and the students, what are some of the things that you might even watch or assess to see how you might approach or work with a particular student”. The assessment process resulted in instructors adopting particular levels of interactions with students.

Professional

The first level of interaction described by instructors was termed the “professional” level. It included the interactions that primarily related to the function of the clinical setting. Interactions at this level involved an emotional distance. Two instructor expressed this as:

Sometimes the boundary [of interaction] is what I would call extremely professional in that it is somewhat distant, and I take my cue from the student, from what they’re willing to give because I don’t believe it’s my right to push...I think that as long as I’m open then they can come and talk to me when they’re comfortable.

I think that in a professional relationship they don’t know you as well...and it’s usually focused on something specific...it’s a professional relationship here, we’re focused on getting the work done and you have people that you develop different kinds of relationships with...and the same with clients, some of those clients its just we’re here to help you get better...but I think professional relationships are very focused. To me a lawyer is someone you form a professional relationship with,

we're just going to sell the house, you know, this is what you need to do, sign these papers here.... Very non threatening and very business like and that kind of cold distant, just do this and everything will be fine sort of stuff.

The most common occurrence of a professional level of interaction was when the clinical participants were getting to know each other immediately following the first meeting.

Most clinical relationships began at this level of interaction as information such as names, student numbers and assignment dates were exchanged. One instructor identified the focussed nature of the interaction by saying:

On orientation day I usually plan it really well so that it minimizes wasted time...the first thing I do is orientate students to the whole general setting like the map of the whole hospital layout just so that they can find their way around and then usually have a little time to just sit down and talk about my expectations and what my style is and how I want them to feed back to me.

The information shared was of a non-threatening and generic nature. The type of information shared was the same type as was shared in any professional situation.

The professional level of interaction began the process of the relationship and established the basis upon which boundaries were crossed.

A professional level of interaction was also maintained in situations in which a student was not meeting the required clinical standard. Often such a situation required the instructor to adopt an approach that was sometimes interpreted as unfriendly or uncompromising. Instructors agreed that in the case of a clinical failure or suspension, it was difficult to maintain anything other than a purely professional level of interaction with the student.

Interpersonal relations are difficult because if there's a disagreement between how you view performance and how the student views it and you can't come to that agreement then that starts creating a whole series of parameters because then you've got to set limitations on what performance is acceptable.

Another instructor related how she had to “lower the boom” on a student who was not meeting performance standards. The instructor expressed a desire for a more personal level of interaction with the student but realized that the emotional realities of a student’s perceptions of failure precluded this. In this case, the instructor felt that her professional obligations overrode the possibility of a more personal level of interaction. Several other instructors also expressed the sentiment that their professional responsibilities came before their relationship with a student. This did not mean that the instructors were mean or demeaning towards a student, just that the dynamics of the situation necessitated some distance and putting aside of personal concerns. An example of this was:

If a student is being unprofessional and neglectful or whatever and so I have to give them some bad news or try to help them shape up, I probably sound fairly stern when I do that, but I try not to be mean or abusive or disrespectful. I try to do it still in a very professional way to let them know where they stand.

Professional with a Personal Approach

The second level of interaction was called “professional with a personal approach”. While instructors primarily focused on the professional purpose of clinical instruction, they began to incorporate personal knowledge of the students into interactions. One instructor expressed it as: “I have a professional ethic that says I can get sort of friendly with some of them, but I’m always aware that I’m the teacher”.

The passage of the relationship across this boundary into this second level was typically a quick and non-threatening process as the instructor began to get to know the students. This process was typically described as:

As I get to know people that I meet, I like to not keep it on a really formal basis so what I find with my students is what comes from my personal life and comes somewhat into my teaching.

Responses to the student became more personal and based upon a mutual level of personal knowledge and collegiality. Interactions were typified by disclosing personal interests, sharing stories during conference time and discussion of professional growth. One instructor stated:

I would say, you know, I really like to do needlework. I like to hike, I like to canoe, those types of things. I would talk about what I like to do and I wouldn't have any problem with that because that connects the student and I on a bit of a different level [than purely professional].

This level was the main operational level for clinical teaching at which learning occurred but in a manner that involved the personal interactions of the clinical participants.

Personal in a Professional Context

In the "personal in a professional context" level instructors related incidents that went beyond the ordinary interactions of clinical teaching. Instructors shared events and stories from their personal lives that normally were not shared. These shared anecdotes involved memories and experiences that were emotionally difficult for the instructor. Instructors identified that they usually shared such information only with those with whom they had a close level of relationship. The reason given for sharing such information with students was that the knowledge of the incident helped students by illuminating a clinical situation. One instructor shared how she occasionally related to students her own chronic struggles with diabetes mellitus:

I will sometimes share personal information if it helps the students to understand where a particular patient might be coming from. For instance I've got a chronic illness, I'm diabetic and so I would share that information not readily but if it was appropriate to share that with them so that they understood from my own personal action and responses to the disease why they might be seeing the reactions in the patient.

She hoped that her experiences helped students understand the processes that patients were going through. Another instructor related how she shared information about her mother's illness in the hope of helping students understand the experience of cancer.

Another instructor related how she shared incidents about her kids as an example of a learning process. A more lighthearted incident related:

If the student is embarrassed about a certain situation and I have an analogy in my own personal life that I feel would support them to close that gap or that they would feel more comfortable coming and telling me then I'll talk about a time when I did something really stupid on the ward.

Instructors related two criteria for crossing the boundary into "personal in a professional context". One criterion was a close level of relationship with the student group. Instructors related that it took a great deal of vulnerability to share information of this personal a nature. If a clinical group was new or unfamiliar then the instructor did not allow such a close level of relationship and self disclosure. The other criterion was the applicability of the incident to a clinical situation. Only if an incident was viewed as significant to student understanding of a clinical situation was it shared.

Personal

The final level of interaction involved an entirely personal level of relationship and disclosure. This level of interaction was reserved for close friends or family. One instructor described it as interacting with "a personal friend, someone I'd invite to my house for dinner".

All instructors indicated that they did not want to either relate with students on this level or disclose information of a strictly personal nature to students. Instructors felt that this level of relationship was outside what was ethically permissible in an instructor-

student relationship. Personal struggles, weaknesses and vulnerabilities were examples given of things that were not shared. Some instructors related that they did not share information about their spouse. Other instructors stated they might share such information but only at a superficial level. Relating and disclosing at this most personal level was viewed as lacking any relevance to the clinical teaching process and thus should not be shared. Instructors felt that "students should not be burdened by the intimate details of your life". The data revealed that interactions between instructors and students on this level caused feelings of discomfort and regret. One instructor related an incident in which she related with a student in a personal manner. The situation involved a student experiencing a crisis due to a family and cultural conflict.

I became very involved with this student and tried to, you know, on a personal level set up options for her...I guess now I have a more clearer appreciation for that particular culture and who am I to judge that maybe that arranged marriage would have been fine, you know, they've been doing it for thousands of years. It wasn't that I was initiating it but the student had come to me. I think it was a boundary I should have established sooner and, you know, directed her to people who were in a professional capacity to help her.

Eventually this instructor had to extract herself from being involved in the situation because the interventions that she was doing to help the student was affecting her ability to be fair to all her students. Another instructor related an incident in which she encouraged a student to pursue a family contact. "[The student] was having problems with her mother and I think it was too late at the time. I think I encouraged her to make a phone call to her mother". In this situation, the instructor felt that it was not her place to be intervening in a family situation. She did not feel comfortable engaging with this student on such a personal level.

Individual Expression of Professional and Personal Delineation

The delineation of the progression from professional towards personal was identified by instructors as an important component of the clinical relationship. Instructors expressed how the pattern of boundary definition between each level of professional-personal interaction was a very personal feature. Each instructor related a differing pattern with which she was comfortable. For example, one instructor related how she disliked a strictly professional approach. Once a clinical rotation began she immediately sought to enter a relationship that involved personal levels of interaction. She shared information about herself very early in the relationship and added a personal dimension to her interactions with students. It was her hope that students would reciprocate soon. She felt free in sharing personal information about herself with students. She still identified a bottom line or personal level of interaction that she did not share with students. This instructor's delineation of professional and personal was an almost non-existent "professional" level, a large "professional with a personal approach" section, a large "personal in a professional context" section and a small "personal" section that she did not share with students.

Another example was an instructor who viewed her teaching as an enjoyable occupation but did not desire a connected relationship with her students. Most of her teaching occurred in the boundary level of "professional with a personal approach". This was indicated by exhibiting personable behaviors intended to make the clinical experience as pleasant as possible for the students. This instructor refrained from interactions on the level of "personal in a professional context", as she lacked the desire to share experiences other than those that were characteristic of a professional level. This instructor's

delineation of professional and personal boundaries was a significantly sized professional level with a very large “professional with a personal approach” level. Her “personal in a professional context” and “personal” levels were almost non-existent, as she would not interact with a student on these levels.

Flexibility of Professional-Personal Delineation

Instructors related that the boundaries between the levels of professional and personal often changed in response to changing conditions within the clinical setting and in the student’s life. One instructor related the following:

I see boundaries [between professional and personal] on a continuum, they have to be flexible and they have to change with the student situation and with your relationship over time with that student. To say there should be no boundaries too is not realistic, to say that there should be rigid boundaries is really unrealistic

Instructors were faced with clinical situations that presented emotional challenges for students. One example of such a situation would be the inevitable occurrence of the death of a patient. While the instructors may not have processed the event in the same way as the student, perhaps due to previous experience in such events, they related being able to empathize in a personal way with the student. One instructor recounted:

I get hooked into sadness very easily too and I have tears and so I can do that with students...if they cry I’m likely to do the same thing, it’s just kind of sympathetic so I guess that demonstrates at least I’ve got emotions and that I’m hearing what they’re saying as far as their emotional concerns in personal emotions.

This identification with personal feelings was also apparent in situations where a student was, for example, experiencing a family crisis. The instructors recounted shifting from the professional role to a personal role in providing

momentary emotional support for the student. This ability to undulate between a strictly professional persona and a personal presentation was indicative of the flexibility with which they related with students in the clinical situation.

Summary

The conceptualization of professional to personal as a series of boundaries was a core concept. Boundaries were grouped into four groups that typified certain types of interactions. The usual progression in a clinical relationship was to start at a professional level of interaction and over time assume a more personal level of interaction.

Connection

Connection was used to describe the degree of relational closeness that occurred in clinical teaching. One instructor aptly expressed it as “it’s people getting to know people”. The data suggests that connection referred to the level of interaction that instructors allowed. Connection was manifested by the amount of familiarity and communication between participants and determined by the crossing of boundaries. Connection occurred in the clinical situation because students and the instructor were placed in a common situation for a common purpose. This assumption shifts the view from “if” connection occurred to “how” it occurred. The following section explores this view.

All instructors expressed a desire to have a more connected relationship with students rather than a relationship based solely on the traditional instructor-student dynamic in which the instructor was the hierarchical expert. “Getting to know the [student] as an individual really does help” was expressed by one instructor. Several themes became evident that described the dynamic process of connection.

The first theme was that connection was a progressive process starting from first contact and ending at the conclusion of the clinical rotation or sometimes long after. In most cases connection was minimal at the start of the clinical rotation but increased gradually throughout the rotation. Some instructors related how eventually they allowed a level of connection that was termed a friendship. Other instructors were very hesitant to use the word friendship in the case of connection with students. Most considered friendship as possible, but only after the rotation had ended. Regardless of where each instructor drew her definition of connection there was a universal acknowledgement of the progressive nature of connection in the clinical relationship.

Another theme was that the level of connection was highly dependent on the individual student and instructor. Two instructors related:

I generally have trouble connecting with all of the students but I do find some students that I immediately relate to easier...those students I just will gravitate to quicker.

The more the student is connected to me, the closer our boundaries would be. Some I never connect with, you know, the students in some groups that never let me in. I will share but it's not an expectation that they will share back and some of those students, our boundaries are pretty far apart or there's a big, a big dead space in between us.

Connection was seen by instructors as a positive indicator of the relational process and a measure of how personal the instructor-student relationship had become.

Instructors put great value on whether students liked them and if they were willing to connect with them. Situations that hampered the level of connection were if a student had a personality that conflicted with that of the instructor, or if there were questions surrounding the safety of a student's practice. In these situations, instructors limited the level of connection with the particular student. Instructors seemed to want a distance that

would allow for the disciplining of the student or the possibility of removal from the clinical group. Such scenarios were unanimously viewed by instructors as unfortunate occurrences.

Connection was never expressed as an assured thing but as a desired and positive situation that often occurred. One instructor expressed it by saying, “getting to know the student as an individual really does help”. Another instructor felt that the level of connection had an impact on the quality of learning for students.

I think it's impossible to learn without some sort of interpersonal connection because the student has to feel safe and you have to know that you're being authentic. I think that for me, a connected learning environment, even if you're slightly towards that professional end of the continuum, you're still who you are as a person and still wanting to be authentic and real.

Concept of Connection

Conceptually, connection closely interacted with the instructors' professional-personal delineation. Connection was pictured as a flexible line that weaved its way between the interactional levels representing professional and personal boundaries (refer to Figure 1). Typically, the level of connection between the clinical nursing instructor and the student began at a “professional” level of interaction. Both the instructor and students probably did not know each other and were seeking to understand how the relationship unfolds. As time progressed and as insights were gained the level of connection crossed into the second level of “professional with a personal approach”. The majority of clinical teaching interactions occurred at this level of connection. Here instructors used a personal approach to relate with students. Instructors shared humorous stories from their past, analogies from their working experience, and related with students on a first name basis. Both the instructor and student knew a bit about each other and used this knowledge to

inform conversations that related to learning situations. The level of connection was not described as a friendship but more as an amiable working relationship.

In the data, instructors identified situations in which the level of connection entered into the third area of "personal in a professional context". This level of connection was less frequent, reserved for special situations and required a deeper personal investment. There remained the professional context of learning but a very personal issue or revelation was introduced into the relationship. A phrase descriptive of this level of connection would be a close working relationship in response to a specific learning situation.

Situations involving the last area of "personal" were rare. A level of connection that strayed into this level resulted in discomfort and a desire for distance from the situation. Several instructors related times in which they felt uncomfortable because of the intensely personal nature of a student's interaction towards them. One instructor related incidents in which her boundaries were threatened. She said: "a couple of times the students...came on really sweet, honey, sucky. It's almost like they're trying to make a personal relationship". As the instructor was relating this event her face was strongly expressing the negative emotions of this event. Another instructor related how "a lesbian woman who thought that since I was single and not married and that maybe...and I'm not and so it was very difficult, but she had to understand that I was not interested in that lifestyle". This instructor related her sincerity towards the student but made it clear that a personal relationship was not possible. In both of these cases the highly personal nature of the interaction crossed a boundary that was intolerable for the instructor. The result, in

both cases, was that the instructor greatly decreased her level of connection from the student causing an emotional distancing to occur.

Trust, Mutuality and Respect

Instructors identified trust, mutuality and respect as three conditions that created or allowed connection. Trust was demonstrated as the ability to let a student work independently in situations that required responsibility. This was seen as students taking responsibility for their own learning. Students were perceived as trustworthy if they sought help when appropriate and did not pursue an action that they were incapable of doing safely. Instructors related that being calm in tense situations as well as keeping their promises was important to secure the trust of students. Students fulfilled their obligations by seeking assistance appropriately but the instructor demonstrated trust by letting students work in a manner that was most beneficial to student learning. One instructor made the link between mutuality, trust and connection by saying:

As a teacher...you're there for purposes of mutual learning, you're not there for your own benefit as you would be in a friendship...I think that a connected learning environment is exactly what you should always try to achieve where there is that trust and that feeling of connectedness and respect...I think that its quite possible to hold those two things simultaneously, that mutual trust and connection

Mutuality was identified as being essential to a greater level of connectedness. Mutuality occurred when both participants in the clinical relationship were cooperatively committed to the learning process. One of the most trying situations identified by the instructors was if a student was not committed to learning nursing or had ulterior motives for being there. One instructor related a story in which a student had been pressured by her parents to attend nursing school. The student did not demonstrate a commitment to

learn nursing causing the instructor to misuse a significant amount of time trying to help the student.

Mutuality at a basic level was also abstracted as treating both the instructor and student as worthy of respect. One instructor related that "if students are open and they're willing to receive a teacher as who the teacher is, in most instances I'm willing and open to receive the student for who a student is". The instructors in this study expressed a sincere desire to give students a sense of being successful and feeling good about their clinical work. They only hoped that students would do the same in return.

Respect was viewed as a basic human function of valuing another person. One instructor in particular saw respect as fundamental to any relationship, especially one with the objective of higher learning. References to what demonstrates respect were vague but the concept was held to be of great importance.

Trust, mutuality and respect were factors seen to greatly influence the dynamics of connection. Instructors expressed a reluctance to pursue a level of connection with students who demonstrated difficulties with trustworthiness and respect. Instructors also identified that these attributes were essential parts of their responsibilities to students.

Summary

Connection was interpreted by instructors to mean the closeness of the clinical relationship. Connection typically started at a professional level and then became more personal as time progressed. Connection was affected by the dynamics of trust, mutuality and respect. Having a connected relationship was viewed as benefiting the learning of both the instructor and student.

Self Disclosure

Self disclosure was the act of disclosing information about oneself to another person or group. This was an important consideration in the understanding of how boundaries were expressed by instructors. Some instructors were comfortable with self disclosure and initially let students know quite a bit about themselves. Other instructors shared a minimal amount on orientation day and then shared more as the relationship developed. All instructors related, however, that a certain measure of self disclosure was essential to the clinical relationship.

All of the instructors disclosed some clinically relevant information about themselves on the orientation day to make students feel more comfortable sharing, to make themselves come across as less intimidating and to instill a sense of credibility.

Students really want to hear what your experience has been. It sort of establishes your credibility, if you can give them examples of, you know, various things. I have no problem disclosing any kind of experience or what not as long as it is professional but, the students are always curious.... Well the first thing we usually do your usual round robin and everybody introduces themselves but then I tell them a bit about my past and I say you can ask me, you're willing, I'm quite open, you can ask me any question that you are curious about.

The purpose of self disclosure was threefold. First, self disclosure was a basic means of getting to know another person. One instructor related that "there is the certain amount of self disclosure that's just building relationship". Instructors shared that if a student was unwilling to share anything about her/himself then it was difficult to relate with them. Instructors realized that students were less familiar with the instructor than the instructor was with the student. Instructors wanted to come across as approachable and friendly. Another quality that instructors wanted was for students to trust their competency. This was phrased as the credibility of the instructor.

Secondly, self disclosure was seen as a mechanism to make the learning environment a better place for students:

I'll share information with students if I feel that it will support their learning or it will support our relationship, the relationship between the two of us getting better, or more personal in the way that therefore the student would feel more comfortable to come to me if they have a problem.

It was hoped that self disclosure helped students understand their instructor better as a person, thus decreasing student anxiety and making the learning environment more hospitable. Instructors related that students felt vulnerable in the unfamiliar environment of the clinical setting. Another instructor related that by "allowing them to know us a bit, the more they can relax, the more they relax, the more they'll learn". Instructors seemed to sense that if students knew them better that clinical would be a less intimidating place.

The third purpose of self disclosure was to help instructors understand students better. This purpose related more directly to students as it was the student's self disclosure that was desired.

I also find that sometimes by disclosing personal information, the students are more ready to disclose information about themselves. That again gives you insights into their, their performance, their interests, their needs, that sort of thing.

Instructors hoped that a greater understanding of a student helped them give more individualized teaching to the individual.

Concept of Self Disclosure

Self disclosure was a concept that related closely with the issue of connection. Instructors related that the type of information they shared with students was largely determined by the level of professional-personal connection that they had with students. Instructors equated a more personal level of interaction with greater sharing of their own

experiences, stories, and thoughts. One instructor related that she “would rather be an ‘in your face teacher’, who knows about her students and who shared her life with students”.

Instructors expressed a sincere desire for clinical time to be more than just the professional activities of learning nursing. Instructors were willing to engage with students in some rather personal discussions if there was a correlation to the clinical learning situation.

I tell students all kinds of things. I tell them about who I am, I tell them about the mistakes I made as a student or mistakes I’ve made as a nurse or different things that I saw as a nurse. That’s what students are interested in.

Instructors wanted clinical time to be enjoyable and relational for both students and themselves. Consequently, they were willing to talk about a variety of topics and student concerns. If one of their own experiences related to the discussion in clinical they frequently disclosed the experience.

Instructors were also clear that if they did not feel comfortable in sharing that they refrained from doing so. One instructor related that students “can ask me any question that they are curious about...personal or otherwise but if I don’t feel comfortable answering it I’m not going to”. This statement implied that there was a proper time and place for self disclosing and personal sharing. All of the instructors were also clear that if a student did not want to share information, they respected that wish. Instructors identified certain things that they never shared with students. These included discussing topics such as sexual orientation, personal intimacies with a spouse and vulnerabilities.

There was an exception to the view of self disclosure as an outworking of the desired level of connection. It was an instance in which a personal situation in a student’s life affected her performance in the clinical situation. One instructor related saying to a

student, “ I don’t need to get into your business but if it affects what your doing on the ward then it becomes my business”. Only one instructor indicated any reciprocity in this principle by stating that she would let students know if a personal issue was influencing her performance as an instructor.

Summary

Self disclosure was used by instructors to describe the purposeful sharing of information about themselves. Most instructors were comfortable sharing information about themselves as long as the information was relevant to the clinical situation. Self disclosure was linked to the delineation of professional and personal connection by the belief that self disclosure created a more personal level of relationship between clinical participants.

Time Influencing Boundaries

Instructors related that their interpersonal boundaries were also influenced by the amount of time spent together with students. Instructors described how students felt freer to approach them as the rotation progressed and as rapport was established between the instructor and the student. As well, instructors stated that they relaxed their boundaries over the course of a clinical rotation and let students get to know them in a more personal manner.

Instructors identified that they were very aware of the time limited nature of the relationship established in the clinical teaching situation. Clinical rotations typically last from a few days to a few months but ultimately the relationship does end. This finality influenced how instructors allowed boundaries to be crossed. Two instructors expressed this as follows:

Some students will completely know me quite well in that three month period of time and other students will hardly know me...you know, how much personal information do you share with individuals that you're only going to know or be close to for three months.

You're very circumscribed by time, you're together for twelve weeks...and that sort of your time period I have to maintain certain distinct boundaries in terms of how much I get to know students and how much they mean in my life and because they go away.

Instructors reacted with a real sense of regret in their voices to the time limited nature of clinical teaching. It was though if instructors desired longer rotations so that they could get to know students in a more personal manner. Several instructors recounted that if clinical rotations were longer they would relate more personally with students.

Preconditions that Inform Boundaries

Instructors identified several preconditions that influenced and informed their conception of boundaries. These preconditions were factors that accompanied or informed the instructor's delineation of boundaries and arose from the instructor's conceptualization of relationships. They were formed by the instructor's experience and personality, the clinical environment in which the instructor taught, and her culture and gender beliefs. These formed the foundation upon which the relationship with the students was established.

Experience

One of the factors that instructors used to inform their boundaries was their personal and professional experience. Instructors shared how their personal experiences as nursing students influenced their view of clinical teaching. Unfortunately, most of the references were quite negative. Several instructors used the term "very rigid" to describe

their learning experiences. One instructor commented that she was going to quit nursing once she finished her training.

I was trained back in the old days... I had horrible experiences. When I graduated from nursing I was never going to be a nurse, I went immediately to university and started a BA because I was not ever walking back in a hospital... I had done very well but I hated the way we were treated and the one thing that I hated most is that we were told not to think, that thinking wasn't necessary, I just needed to follow the orders and so when I graduated I thought well, I've had enough of this.

She related that later in her nursing career she determined that there was a different way to be with people than the way she was treated as a student. This provided a motivation for her to pursue making nursing education a more friendly place for students. While not all instructors were as explicit, all of the instructors related a desire to make the instructor-student relationship a more pleasant experience than the one they had experienced.

The professional experience of instructors also influenced their boundaries.

Several instructors related incidents when they were novice instructors in which they either crossed a student's boundaries or allowed their own boundaries to be violated.

I think now I'm much better then when I first started teaching. Initially, I felt like you had to be there for the student and if it meant them calling you at home or being available to students at any time, any place it was acceptable for a student to approach you. That's the way I was when I first started teaching, when I didn't have enough experience and actually I think it was detrimental at that time

Another instructor related a time when her boundaries were crossed in a manner that made her uncomfortable:

The first couple of times that it did happen, I felt very uncomfortable. I wasn't sure what I did and I acknowledged this. I didn't deal with it straight away but I went to a colleagues and discussed it with them, I wanted to speak with someone with experience in this area.

Instructors related that as they grew in experience they gained an increased understanding of how comfortable they were with certain interactions with students.

Experience influenced instructor boundaries by creating a picture for how boundaries should be delineated. How instructors saw the ideal instructor-student relationship was a reflection of their own professional and personal experiences. Most instructors used examples of past relations with students to delineate what constituted both a great relationship and a bad relationship.

Personality

Instructors felt that their personality greatly affected how they were as teachers. One instructor related how “you bring who you are to a [clinical] situation”. Another stated that “how I am as a person is how I am as a teacher”. Another instructor related that “I do believe that your own personality is important in terms of how you relate to people, really makes the kind of differences in a teacher”. Another instructor stated that “we’re all human beings [in the clinical setting]...and that there are a lot of circumstances that can affect who you are [as a teacher]”. Instructors realized that they brought a lot of themselves to the clinical situation.

Personality seemed to influence where boundaries were set both at the beginning of a clinical rotation as well as throughout. One instructor related how she fluctuated on a day to day level saying, “we’re all human beings and so sometimes the boundaries will be, some days I’ll be a little more, empathetic than other days depending on what’s going on in all of our busy lives”. Another related the following:

There's times when you can't handle any more and then you need to put a bit of a wall up and but then I think the wall can come down and its recognizing that its

time to take it down that whatever was bothersome or what was irritating is now gone and so now we can go back and relax a little bit.

Certain types of personalities were viewed as being ideal for clinical teaching.

Most instructors admitted that having a personality that finds it easy to interact with others was an important quality in a clinical instructor. As well, instructors who were more compassionate with students were seen as more successful:

Those instructors I think are the ones students will tend to remember as well, the ones who really helped them through difficult situations or brought them into a new understanding or help them to put something together that they just hadn't been able to make sense out of... But I think it's also interpersonal. And some people just have a compassion or a warmth and other people don't and some of them have sort of in between.

None of the instructors felt that they possessed problematic personalities so there were no references to how poor personality might influence how an instructor taught. Some instructors felt that they were "laid back" but this fact did not seem to automatically translate into a boundary definition. The instructors' past experiences with harsh and rigid instructors did have a great impact on how they said they related with students.

Personality affected boundaries in that it defined the instructors' way of approaching students. This manifested in instructors' rituals of getting to know new students as well as in the use of relational mechanisms such as humor and compassion. Personality was a precondition because it was something the instructor brought to the clinical situation.

Environment

Instructors related how the clinical teaching environment influenced their boundaries with students. Most instructors were willing to relax their boundaries and allow a closer level of interaction if it made students feel safe in the clinical environment or

if it enhanced learning. One instructor related that “[her] purpose was to make sure that all students were as comfortable as they can in, in as far as clinical work concerned”.

Another instructor related:

I also think [students are] colleagues, I also think that they’re learning and they’re working very hard in a very difficult environment and I don’t think we give it enough credence and we don’t recognize the pressures that they put themselves under a lot of times.

An instructor related a time in which the clinical group discussed the death of a client with whom students had spent a great deal of time. She remembered that “one post conference, half of the room was in tears, but this was healthy because this was learning. This was, as far as I’m concerned, getting the emotion out and this is part of our practicing”. This instructor wanted students to feel free to cry if the situation warranted. She regarded this incident as a reflection of the learning environment that she strove to foster.

Gender

All instructors identified boundaries surrounding how they related to students of the opposite gender. This factor was influential in determining the relationship between the instructor and the student, especially concerning the use of physical touch. Several instructors related that they will touch students in a non-threatening manner, but they all drew a definite boundary when referring to students of the opposite gender. One female instructor stated:

I’m certainly aware of the fact that I can’t touch my male students. That sets up a difference immediately [in how she relates to students] but I know that I cannot do that, that that would be an unsafe action for me, so it’s too bad but, you know. I think you have to be careful even where you touch a female student; that’s why I say I usually put my hand on their back. I think you just, you have to be cautious

in this day and age not so much because you're intent is wrong but because people can misinterpret intent and perception is nine tenth's of the law it seems.

Touch was an issue that brought out the clearest delineations of a boundary among instructors. A potential allegation of a sexual harassment was a great concern to instructors. It was an issue that I observed stimulated a great deal of thought and anxiety. Most instructors related that touching students of the opposite gender was not threatening to them personally but acknowledged an honorable intent was not a defense against an allegation of sexual harassment.

Gender views were constructions that were largely set prior to the clinical rotation. It was an influential precondition that resulted in specific boundaries, the most notable being touching students of the opposite gender.

Culture

Instructors admitted that they held certain views of how to provide culturally sensitive teaching. This influenced their delineation of boundaries with certain cultural groups that have different ways of conducting relationships especially in the context of the instructor-student relationship. Several instructors described experiences of having students of Asian descent who were uncomfortable with the instructors' delineation of connection and self disclosure. One instructor recounted her experience: "[in the] Asian culture, the students, I think, have not been ready to ask questions, to question authority, to be assertive and so they do tend to be quiet". In this case, the instructor initially adopted a more professional approach with the student. She gave the student more freedom to not engage and then she attempted to find a level of interaction that was comfortable for the student. Several instructors related feeling overwhelmed when dealing

with members of unfamiliar cultures. One instructor related a story in which she became personally involved in a student resistance of the cultural practice of an arranged marriage. She related that "I see now I was in over my head and I didn't have as good an understanding of the culture as I thought I had". This instructor regretted her actions in dealing with this incident. The incident prompted her to adopt a boundary of avoiding getting involved with personal issues surrounding a student's cultural practices. This incident highlighted how much instructors' conceptualization of culture can affect how boundaries are formed.

Summary

The instructors identified their own experience and personality, the clinical environment, and cultural and gender views as the significant preconditions that informed the relationships that were established with students. These identified preconditions formed the basis by which the instructor began the process of boundary crossing with students.

Definition and Construction of Boundaries

Boundaries were defined by instructors as limitations in the clinical relationship. The construction of boundaries emerged as the manner in which the delineation of boundaries was brought together incorporating the preconditions, connection and self disclosure. This section will primarily address the construction of boundaries but with the understanding that the definition of boundaries is what gives the discussion its substance.

Boundaries gave instructors a sense of personal protection from having a relationship that was uncomfortably close. Instructors were clear in wanting to have an amiable relationship with students but always identified a bottom line beyond which they

would not proceed. Having the option to “pull back” from students and have a distance was something that several instructors mentioned as important. Three instructors related incidents:

If I’ve mistakenly given the student that wrong impression, I just have to set up those boundaries a little bit.

I had to just be very clear and kind of cut off any sort of relationship.

I definitely recognize that as you’re a clinical instructor you are in a role of authority...it is unfortunate in some ways but I think it’s fortunate in others to have that identified boundary

Boundaries were seen as mechanisms whereby the instructors maintained a comfortable relationship with students without feeling as if they had no control over how the relationship progressed. Boundaries also protected the instructor from investing too much in a relationship that was limited by time. One instructor eloquently expressed her view saying “it is one more loss, you know, so I have to maintain certain distinct boundaries in terms of how much I get to know you and how much you mean in my life and because you go away”.

Another attribute of boundaries was that they created a distance that allowed the instructor to function in the role of evaluator. One example quoted by an instructor was this:

I think when people get into difficulties is when they allow that boundary to go so far and they’re very lenient in their boundaries and then when they’re forced to be put in that role of evaluator then they have a very difficult time doing it and the student, I think, doesn’t accept that role really easily if you’ve been so loose with your boundaries before that.

Another instructor regretted the boundary that was created due to her role as an evaluator:

I find some students very resistant and hesitant to that and I think it's their whole notion of teacher and authority and evaluation and I think evaluation is prime in student's minds when they're in clinical, they think their life is on the line the entire time they're there.

This instructor modified her boundary position in response to students in the hope of minimizing their fear of evaluation. In both of these cases, the instructors identified how the evaluator role influenced boundaries.

How a particular boundary delineation affected the learning environment was one construction of interest among instructors. One instructor discussed the difference between having boundaries that were "stringent" and "lenient". She expressed that lenient boundaries may have a value in making a better clinical environment. What follows is a portion of the interview between the instructor and the researcher. "P" refers to the participating instructor and "R" refers to the researcher:

P: When I just look around at our faculty and compare myself to my colleagues, I can fit them into, if you're looking as far as boundaries, people that are very lenient, people who are the middle of the road and people that are more stringent and I probably fit towards the more stringent area...and I think that definitely comes from my upbringing, my idea of what is most effective for students and, you know, I'm moving more hopefully towards the mid line...So I do it but I'm still very guarded because of, you know, what I've seen

R: Do you see the middle as being more ideal?

P: I do... Yeah, whether it is or not I don't know but from looking at individuals that work with me that are what I consider middle of the road, they just seem to be more happy in their work, their students are happier...it could be just a factor of their own personality but I see myself as I get more that way.

This instructor viewed closer relationships with students as a reflection of more lenient boundaries. This perception was common among other instructors as well.

Instructors saw the success of the clinical relationship as an indicator of their skill as instructors. This pressure to be considered a "nice instructor" was implicit in many of

the interactions related by instructors. One instructor thought that "maybe they might not like me as well professionally. I think that I have a really nice personality and therefore if I can get in there on a personal level then that may flavor the professional". This pressure affected instructor boundaries by making them feel that they had an obligation to have boundaries that were more easily crossed.

The Process of Boundary Crossing

Instructors identified a process they termed 'boundary crossing'. When a boundary was crossed, a decision making procedure was enacted to permit or not permit the boundary be crossed. This decision making procedure was best described as a negotiation process in which two or more people seek to work out the relationship between them as opposed to a typical adversarial approach of an employee-union relationship. In the clinical relationship the negotiation process involved both verbal and non-verbal communication and was not always a formal communication process but often involved subtle interactions between the instructor and student.

Boundaries were identified as various levels between professional and personal. Initially boundaries reflected a professional level of interaction. As the instructor became more acquainted with students they permitted boundaries to be crossed, allowing more personal levels of interaction to occur. In most cases, the crossings were within the comfort level of the instructors. If a boundary was crossed that was too personal for the instructor a re-negotiation occurred as the boundary was readjusted.

The progression was not a purely linear progression from professional to personal as instructors gave examples where they crossed and re-crossed boundaries. Instructors

identified situations in which they interacted on a more professional basis with students for a while but then became more personal again.

There's times when you can't handle anymore and then you need to put a bit of a wall up and but then I think the wall can come down and it's recognizing that it's time to take it down that whatever was bothersome or what was irritating is now gone and so now we can go back and relax a little bit.

Some instructors felt comfortable having a closely connected relationship in which their uncrossable boundary was occasionally challenged. Such instructors freely shared personal information and were tolerant of interactions that closely approached the uncrossable boundary. Other instructors had a much more reserved manner of interaction. Such instructors conducted their relationships in a less connected manner, self disclosed less, and reacted stronger to intrusions into personal topics. The important question in instructor boundaries was not if boundaries were crossed, but how they were crossed.

Boundary Crossing by Self Disclosure

The informal process of boundary crossing began upon first contact between the instructor and her students. These crossings determined how the instructor moved between a professional level of interaction and a more personal level. The passage, through the various boundaries, produced the relationship that was experienced by the instructor and the student. Some instructors began the negotiations on the premise of desiring a close level of connection with students creating an important social and relational experience. Other instructors began from the perspective of desiring a degree of separation. Clinical teaching was an occupation that they enjoyed but not to the point of wanting it to be a social experience. Regardless of the motivation, the clinical relationship

necessitated that boundaries be crossed. What was ultimately decided was how boundaries were crossed and at what point those boundaries stopped being crossed.

The first boundary to be crossed involved the self disclosure of information such as the instructor's first name. The crossing of this boundary was fairly automatic due to the non-threatening and obligatory nature of the information. Instructors freely shared information such as she might share with a store clerk, bank teller or possibly a stranger.

Hypothetically speaking, each time the instructor disclosed more information about herself a decision was made to share information or to not share at all. If the instructor was to undermine the process of crossing this boundary by either giving a false name, insisting on a formal title, or not giving her name, then the clinical relationship would be severely restricted. Such a scenario did not occur with any of the instructors' clinical groups. Sharing information, such as a name, involved making a choice to divulge but usually the choice was automatic due to the non-threatening nature of such information. Information such as reasons for pursuing nursing or one's previous school and clinical experience was also shared on orientation day but such discussion easily avoided any personal divulgence.

As the clinical rotation progressed, other information of a more personal nature was shared. Information about the instructor such as where she went to nursing school, why she wanted to be a nurse, and hobbies or sports interests were shared with students. Self disclosure of this nature was characteristic of the "professional with a personal approach" level of interaction.

Information that was even more personal was shared as the clinical rotation progressed. Instructors related that sharing such information represented a significant

boundary crossing and required a significant emotional investment on the part of the instructor. What facilitated these crossings was that other boundaries had been crossed previously giving the instructor a sense of security in the relationship.

Boundary Crossing and Level of Connection

Connection was similar to self disclosure in that there were corresponding changes as the level of interaction went between professional and personal. A professional level of interaction was reflective of a lower level of connection and a personal level of interaction reflected a high level of connection. Instructors considered the transition from a low level of connection to a higher level to be a indication of boundaries being crossed. The general trend in the clinical relationship was a progression from a lower level of connection to a higher level but this was not always true. One instructor mentioned that "some students will completely know me quite well in that three month period of time and other students will hardly know me and I will hardly know them".

Instructors indicated that the boundaries between a lower level of connection and a more moderate level were crossed without much concern. This was reflective of instructors' desire to have a more connected relationship with students. Problems arose when the level of connection reached a level that was too high. Instructors were unable to clearly delineate the point at which this occurred but they were clear in that they knew a boundary had been crossed that caused discomfort. One instructor related a particular interaction with a student stating that "something in my gut didn't feel right about it... I remember feeling this isn't right or something". Another instructor described an experience in which she related with a student on personal level of connection:

I became very involved with this student and tried to, you know, on a personal level set up options for her, which sort of complicated things so, and I know now I would never ever do that again. I think it was a boundary I should have established sooner.

Point at Which Boundary Crossings Stopped

All instructors identified a certain point at which they did not allow any more boundaries to be crossed. This will be described as the uncrossable boundary and represents the division between what was allowable in a relationship and what was not. This uncrossable boundary was manifested in the information that instructors self disclosed as well as the level of connection that was allowed. Beyond this boundary were certain memories, experiences, relationships and self-expressions which were reserved for close friends, a spouse or themselves alone. One instructor shared that “my comfort zone is to be a real person but to stop short of the level of intimacy that you would have with a friend”.

Instructors related that often they did not recognize that an uncrossable boundary had been violated until after the fact:

You're working with students in such tenuous situations. You know it's easy, I think, to cross a boundary that you're not comfortable with before you even recognize that that has happened.

The usual reaction when an uncrossable boundary was challenged was described as an uncomfortable feeling. One instructor stated that she experienced a “feeling in the gut” that indicated to her that something was wrong. If an uncrossable boundary was challenged the most common reaction was for the level of interaction and connection to go from personal to quite professional. Several of the instructors related incidents where

they backed away from a student and then resumed the relationship at a new, less intense level of interaction.

The level of connection that represented the last crossable boundary differed in all instructors. Some instructors who felt comfortable having a closely connected relationship with students interacted in a close manner prior to this boundary being challenged. These instructors freely shared personal information and were tolerant of interactions that closely approached the uncrossable boundary. Other instructors had a much more reserved manner of interaction. These instructors conducted their relationships in a less connected manner, self disclosed less and reacted stronger to intrusions that challenged their uncrossable level.

Summary

Boundaries defined the types of interactions that occurred between the instructor and the student. The main conceptual function of boundaries was the delineation between levels of professional-personal interaction.

Boundaries also created a framework whereby the level of connection between instructor and student was expressed. This was particularly so with regard to the defining the point in the clinical relationship where greater connection stops: the uncrossable boundary. Boundary delineation was partially defined before the instructor began the clinical relationship by the preconditions that she brought with her, but was primarily influenced by the dynamics of the relationships in the particular clinical rotation.

Boundary crossings did routinely occur but were part of the normal relational dynamics of the clinical relationship.

Chapter Five: Discussion of Findings

Introduction

This chapter will discuss the findings of the study. Selected parts will be examined in conjunction with the literature. This discussion will enhance the understanding of the topic of boundaries and place of this present research study in the current literature. The topic of interpersonal boundaries has received little attention and research in nursing education. The nature of professional and personal interactions will be discussed followed by a discussion of connection and self disclosure. Finally, boundaries will be discussed.

Nature of Professional and Personal Interactions

Professional-personal delineation emerged in the present study as a major means of how boundaries were described. There was confusion, however, as to the implications of professional and personal interactions. In the present study, the examination of “personal” and “professional” as characteristics of interactions was considered to be a minor factor in the construction of boundaries. My earlier thoughts presumed that a professional-personal delineation was either a reflection of instructor personality or just a different way of saying ‘work versus home’. The Registered Nurses Association of British Columbia, Registered Psychiatric Nurses Association of British Columbia, British Columbia Council of Licensed Practical Nurses (1994) and Milgrom (1992) followed the work versus home perspective in their use of professional and personal. In the present study, however, the separation between professional and personal became less distinct.

The view of authors such as Tauber (1998) and Pope (1989), who suggested that the inclusion of the personal in a professional teaching situation will lead to unethical relationships and a decreased ability to teach effectively, advocated a clear separation

between professional and personal. Professional boundaries were articulated by these authors as the means to conduct practice in a safe manner. Instructors in the present study did not share this view. In the interviews, instructors initially voiced the popular notion of a separation of professional and personal in their clinical teaching. As the interviews progressed, however, a different view began to emerge. Instructors expressed a desire for a relationship with students that minimized separation and allowed personal expression. The instructors shared incidents in which they revealed personal information to their students about themselves and their experiences. This represented a breaking down of the initially expressed view of a need to separate professional and personal.

Did the instructors' desires for a relationship that was based on a minimization of separation exemplify gross boundary violations by instructors? Or were they just normal responses to a relationship situations? Instructors seemed to be divided between two opposing views of professional-personal delineation. There was a view that it was important to maintain a clear boundary between professional and personal (Milgrom, 1992; Tauber, 1998). The opposing view espoused breaking down boundaries and promoting greater personal interaction between the instructor and student (Murray, 1989; Gaines & Baldwin, 1996). This tension between the two views resulted in confusion when defining what constituted a professional and personal boundary.

Tom (1997) addressed this tension by discussing her perceived conflict between her position of power in being a professional instructor and her feminist beliefs about having a personal level of interaction with students. Although some instructors in the present study initially maintained a separation perspective, when instructors enacted their

boundaries in the clinical setting they tended to act in accordance with the views presented by Tom where professional and personal characteristics were merged.

Instructors in the present study asserted that rigid boundaries between professional and personal caused an unwanted degree of separation between themselves and students. This finding was supported by Stanford & Roark's (1974) research, which suggested that the inclusion of the personal in the instructor-student interaction was essential to effective learning. Most instructors in the present study were willing to allow a significant amount of personal investment in the clinical relationship if certain conditions such as trust, mutuality and respect were present and if they retained control of the point where their boundaries would not be crossed. Instructors ultimately desired interactions that were characteristic of an integration of professional and personal.

Confusion from Nurse-Client Relationship

One of the primary roots of the confusion over professional-personal delineation may be that nurse educators have mistakenly interpreted the instructor-student relationship to be of the same nature as a nurse-client relationship. Nursing literature discusses a distinct boundary between the nurse and the client. One example of this was the National Council of State Boards of Nursing (1996) which advocated that:

Professional boundaries are the limits of the relationship that allow for a safe, therapeutic connection between the professional and the client. Boundaries protect the space between the professional's power and the client's vulnerability. Boundaries allow professionals to control this power differentiation and provide for a safe connection based upon the client's needs (p. 1).

The nurse client relationship carries with it the connotations of recovering from a health challenge and being in need of health teaching. I believe that this application to the clinical

relationship has been erroneous and has influenced instructors to have an inaccurate view of how they are to relate with students. Students do not inherently have health challenges and are often in a position of providing great learning experiences for instructors. Therefore, maintaining such a perspective minimizes students and interprets professional-personal delineation in an incorrect manner.

In summary, the description of professional and personal delineation became a major focus of the present study. Instructors' views of professional-personal delineation as a process allowed the integration of both concepts and avoided the separation view erroneously applied from the nurse-client relationship. This study presented a more comprehensive view of the instructor-student relationship by including both professional and personal attributes in the discussion of boundaries.

Connection

Both the present study and the literature identify connection as a component of the relational process. The process of connection and hindrances to connection will be discussed in this section.

Process of Connection

Much of the literature pertaining to the clinical relationship advocated a closer level of connection between instructors and students (Hezekiah, 1993; Downey, 1993; Hedin, 1989; Gaines & Baldwin, 1996; Symonds, 1990; Higgins, 1996; Grams, Kosowski & Wilson, 1997). Instructors in the present study felt the same. What was not clear, both in the data and in the literature, were the motives for desiring a greater level of connection, how the process of greater connection was accomplished, and what effect this had on the learning environment. What instructors seemed to desire was the ability to

interact with students using a friendly expression of their personalities. Both Handson and Smith (1996) and Dillon and Stines (1996) identified this as instructor-student caring interactions. The literature advocated connection in the instructor-student relationship and the data indicated that instructors desired it. It is somewhat perplexing, then, to note that instructors described tremendous variability in the level of their connection with students. I believe that this is in part due to the incorrect view of boundaries being representative of an absolute line beyond which a relationship is considered to be destructive. This view was held by numerous authors (Wuest, 1998; Guthiel & Gabbard, 1993; Owen, 1995; Bruhn, Levine & Levine, 1993; Brown, 1994). Greater connection, though a desired outcome, was viewed as fraught with potential hazards such as sexual misconduct (NCSBN, 1996) and dual relationships with an enmeshment of professional purpose and personal need (Kagel & Giebelhausen, 1994). The present study's data acknowledged connection as an indicator of the relationship process but did not assign a moral or ethical value to the process. Greater connection became merely a descriptor of the relationship process rather than a point approaching an unethical boundary. This view of connection allows instructors to operate using a flexible approach that allows connection but also permits the limitation of connection if this is desired. I believe that the approach identified in the data made connection appropriate to the level of relationship that was desired and allowed by the clinical participants. The instructors were free to experience the positive dynamics of the relationship with students while they maintained the ability to withdraw if necessary and to delineate where boundaries stopped being crossed.

Student Choice as Facilitation or Hindrance to Connection

In the present study, student choice was also viewed as a potential facilitation or hindrance to connection between the instructor and the student. Instructors described an assessment process that sought the willingness of students to engage in dialogue and connection. Students were not required to share and could maintain a strictly professional level of interaction if they chose. Instructors in this study were clear that they preferred interacting with and teaching students who were willing to connect with them. A student who was willing to facilitate the process of connection was seen as interested and committed to the learning process.

Unfortunately, the literature failed to explore the possibility of a student choosing not to connect with an instructor. A study by Hanson and Smith (1996) that examined students' perspectives on caring and non-caring interactions with instructors assumed that all students wanted a level of connection with their instructors, which neglects the aspect of student choice. Other studies by Beck (1991), Higgins (1996) and Grams, Kosowski and Wilson (1997) examined the level of interaction that students have with their instructors, but the students' perspective was absent or it was simply assumed that students desired greater connection with their instructors. My own experience has shown that students often feel pressure to be pleasant, to have the appearance of enjoying the clinical rotation and to be friendly with instructors. I believe that an amicable level of connection is often preferable and often makes the hardships of the clinical situation more tolerable for instructors and students. However, I think that instructors must be careful not to equate a student's choice to assume a low level of connection as an indication of unwillingness or inability to participate in learning.

In the present study all of the instructors chose to connect with their students. It is possible, though, that an instructor may choose to not pursue a level of connection with students. The nursing literature did not acknowledge the possibility that an instructor may not choose to pursue connection. Although nursing instructors in the present study chose to connect with students, many were clear that the level of connection had an individually defined end point. The data seemed to suggest that connection with students was desired but only to a point. Instructors seemed to avoid equating a particular level of connection with successful teaching. What was more important was the process of connection and the results of the connection.

Self Disclosure

Self disclosure emerged as a theme for which the literature and the instructors in the present study were in congruence. In the literature self disclosure was described as the process of sharing information with another person to illuminate an unknown aspect about oneself (Collins & Miller, 1994). It was also viewed as a means of promoting greater connection between individuals (Brown & Walker, 1990). A process of introductory dialogue occurring in the first clinical session was described by Hedin and Donovan (1989) as consisting of the instructor introducing herself and asking the students to do the same. Instructors in the present study followed a similar pattern as that described in the literature. They desired to let students know about themselves and frequently described disclosing information about themselves during orientation. There was no reference in the literature, however, to the purpose of the information gathered or if the sharing caused any challenge to interpersonal boundaries. Gaines and Baldwin (1996) made the most

explicit endorsement of self disclosure by advocating mutual disclosure as a part of the “development of authentic relationships, a coming to know one another” (p. 126).

The present study revealed that instructors were concerned with the potential that self disclosure would result in crossing a personal boundary. This concern resulted in an interesting selectivity in what was shared with students. In the data instructors reported variances in the quality and quantity of information disclosed. For example, instructors spoke of times they felt comfortable sharing relatively intimate information with students, given a particular context and educational purpose. Some instructors expressed a concern about sharing an excess of information. The exact mechanism of the concern surrounding the nature of self disclosure was unclear, but I suspect that it was due at least in part to the basic vulnerability that results from divulging information about oneself to another. The literature does not speak to this issue and so it becomes evident that further study would be helpful.

In summary, self disclosure was practiced by instructors and advocated by the literature. The purpose and place of self disclosure was still not apparent, however. Self disclosure involved a vulnerability that often caused difficulty for instructors even though they endorsed it as a means of becoming more familiar with students.

Boundaries in Nursing Education

The discussion of interpersonal boundaries was of great interest to the instructors who participated in this study. Terms such as professional, personal, connection and self disclosure were frequently used. In the data boundaries were conceptualized as limitations in the relationship. These issues will be discussed in the following sections.

Terms Used to Describe Boundaries

In the present study, all of the instructors displayed a great deal of passion for their work in clinical instruction. This was especially true when discussing how they interacted with their students. Instructors preferred boundaries that allowed them to interact with students in a way that made the students feel comfortable learning. Tom (1997) described this process as a "deliberate instructor-student relationship" (p. 1), where instructors' means of relating with students enhanced student learning. Gaines and Baldwin (1996) described this process as indicative of a "transformed student-instructor relationship" (p. 1) and also advocated a greater level of connection. Instructors in the present study were able to describe their boundaries and used the terms "professional", "personal", "connection" and "self disclosure" to describe how they constructed boundaries. The findings of the present study indicated that instructors primarily conceptualized their boundaries using relational descriptors such as professional-personal delineation, level of connection and level of self disclosure. Much of the literature also described the instructor-student relationship in terms of professional-personal delineation (Hoover, 1995; NCSBN, 1996; Milgrom, 1992), connection (Ryder & Bartle, 1991; Grams, Kosowski, Wilson, 1997; Hansen & Smith, 1996) and self disclosure (Collins & Miller, 1994; Derlega et al., 1993; Brown & Walker, 1990). What was not clear in the literature, but was illuminated by the present study, was how professional-personal delineation, connection and self disclosure were reflections of interpersonal boundaries. Literature from other disciplines also added to the potential misrepresentation of boundaries in nursing education by describing boundaries from the perspective of a therapeutic relationship between a psychiatrist or therapist and a client (Guthiel & Gabbard, 1993) or

between a teacher and a child (Rogers, 1996). This was reflected in instructors' difficulty in clearly defining their boundaries. The present study found that interpersonal boundaries involved a process that does not require an absolutely clear delineation. The process component allows flexibility in the defining of boundaries and allows for a broader implementation of boundaries in a clinical situation than has traditionally been described in the literature.

Boundaries as a Defined Limitation

The most common interpretation of boundaries in the literature was of a limiting mechanism in interpersonal relationships. A good example of boundaries as a limitation was given in a community nursing focused article by Wuest (1998) that discussed the role that women played in caring for sick family members. Wuest reported that this role violated personal boundaries and created great stress for the women in the study. The term "boundary" described the level at which the women in the study needed to set limits on how much informal care-giving they assumed. One problem with this article was the conceptualization of boundaries as a bottom line level of interaction in a relationship which provided the ultimate limit to how far the relationship ought to or should be allowed to progress. Many other authors also made this assumption about boundaries as defined limits (Owen, 1997; Webb, 1997; NCSBN, 1996; Hoover, 1995; Guthiel & Gabbard, 1993; Milgrom, 1992). Instructors in the present study also identified boundaries as limiting mechanisms and used the term "bottom line" to describe boundaries.

One criticism I have of a "bottom line" approach, which assumes one rigid boundary, is that the dynamics of the relationship above the boundary are not acknowledged. The boundary only comes into effect when the boundary is approached or

crossed. Such a theoretical boundary perspective merely determines the lowest possible level of interaction before a relationship becomes destructive. Furthermore, the delineation of this low point is an entirely arbitrary decision of an institution, or in the case of the present study, the instructor or student. For example, if an instructor's delineation of the uncrossable boundary was extremely low and allowed intimately personal interactions, a severe boundary violation (as in the case of an unethical relationship) could occur without the instructor's boundary ever being challenged. The issue of greater concern, then, is how boundaries are enacted in relationships. Webb (1997), Owen (1995) and Guthrie and Gabbard (1993) assumed that when boundaries are enacted in a manner described as low boundaries the prevailing result will be unethical relational practices. This assertion was not supported by the present study and I question whether a clear boundary delineation would actually prevent boundary violations.

Boundaries as means of moral constraint

Barakat (1997) and DeCloedt (1997) approached boundaries as mechanisms of moral constraint and protection, and asserted that proper boundaries will prevent moral difficulties such as unethical relationships. The protective mechanism view assumed that boundaries were protective mechanisms and boundary crossing involved a breach of a moral or ethical principle. Instructors in the present study held the belief that boundaries were reflections of a process of boundary crossing. Using this perspective, boundaries were crossed as a part of the normal process of a relationship. I believe that some boundary crossings will produce moral or ethical questions, but certain choices and motives are greater considerations than boundary crossings.

There was a wealth of literature that coupled boundary crossings with the moral violation of sexual harassment (Pope, 1989; Tauber, 1998; De Cloet, 1997; Backlar, 1996). The difficulty with this literature was that there was no explicit process given for avoiding sexual harassment. As well, the issue of the intent of an action was not addressed. Instructors in the present study indicated that they were very cautious to avoid behavior that might be interpreted as sexual harassment. Instructors were aware that such behavior occurred in nursing but did not have any first hand experiences with this. I believe that a better understanding of boundaries will neither deter an instructor who desires to have an unethical relationship nor prevent a student from misinterpreting an action that had honorable intent. A better boundary perspective will likely not address the issues surrounding sexual harassment but I theorize that unethical relationships, which are so frequently quoted as the ultimate result of bad boundaries, are more a result of bad choices rather than a moral outcome of interpersonal boundaries.

In summary, the data in the present study found that boundaries were more than a mechanism of limitation and moral constraint. Boundaries involved a process of relating that grew out of the interactions between the instructor and student.

Summary of Discussion of Findings

In the initial stages of the interviews instructors stated clear positions on their conceptualization of boundaries in the instructor-student relationship. However, as the interviews progressed, the delineation and separation of professional and personal interactions became increasingly unclear and even contradictory. Instructors' shifted from a perspective advocating separation to a view promoting integration. Four major conceptual themes emerged from the interviews, namely professional, personal,

connection and self disclosure. While instructors were uncertain as to the interrelationship between these four concepts they did expound upon each of them. Instructors considered connection to be a desired relational process, but they wanted to maintain the ability to limit its extent in the instructor-student relationship. Instructors also mentioned that students chose to either facilitate or hinder the process of connection in the clinical relationship. Instructors reported using self disclosure as a means to transmit information about themselves to their students. Their level of comfort in self disclosure varied depending on the purpose, context and amount of sharing as well as the level of familiarity with the students. Instructors were unclear as to the relationship between self disclosure and their boundaries. Instructors disagreed with the literature that defined boundaries as limits on relationships or mechanisms of moral constraint. Instead, they proposed that boundaries, though sometimes defined as a bottom line, were a subject to change and the flexibility of a process of boundary delineation.

Chapter Six: Implications for Nursing Education, Directions for Future Research and Summary of the Study

This study's purpose was to examine how instructors define and construct interpersonal boundaries with their students. A naturalistic inquiry method was utilized. The study found that, in the case of the instructors in the sample, interpersonal boundaries were a process of relational interaction. This process was manifested by professional and personal boundaries being integrated as levels of interaction. Connection and self disclosure entered the discussion as means by which boundaries were constructed and expressed. These findings resulted in several implications becoming evident.

Implications for Nursing Education

The findings of the present study illuminated several implications for nursing education. Viewing boundaries as a process rather than a limitation created the need for a transformation in how instructors define and construct boundaries. Significant implications occur for both clinical instructors and students at an undergraduate and a graduate level.

Clinical Instructors

For undergraduate clinical nursing education, a reexamination of the concept of boundaries in the instructor-student relationship will require instructors to examine the conceptualization and construction of boundaries in their own practice. An expanded understanding of boundaries will allow instructors to minimize the internal conflict between professional responsibilities and personal boundary limitations.

Knowledge of boundary delineation will prompt instructors to explore their comfort levels with the concepts of professional, personal, connection and self disclosure.

Instructors will need to explore their process of boundary construction and the degree to which these beliefs are embodied in their teaching. Each instructor will have to personalize the concepts to their own teaching style and personality.

In a teaching environment that promotes less rigid boundaries there will be less emphasis on instructors avoiding boundary conflicts and greater emphasis on developing and enhancing relationship with students. Interactions will occur in a comfortably connected manner while permitting the instructor and/or student the option to limit how personally connected a relationship becomes. This will remove some of the perplexity expressed by instructors over how to interact with students and create a quality learning environment. Instructors may feel vulnerable in the initial implementation of the new boundary concepts. This internal discord may need to be explored and resolution sought through personal reflection and peer consultation.

Undergraduate Students

For students in undergraduate nursing programs, a new boundary conceptualization would require a process of understanding the relationship between them and their instructors. An examination of what interpersonal boundaries are and how they affect relationships could be taught as well as modeled by instructors. Variances in perception will also likely occur among individual students. These differences are likely due to personality, expectation and learning styles, as well as students' unique perceptions formed by a multitude of individual factors beyond the explorative scope of this paper. However, this also requires instructors to be keenly aware of the receptivity and responsiveness of the student regarding boundary formation and enactment. Another factor related to students is the quality of the learning experience. Students will likely

have vastly differing views on how boundaries influence their learning. This creates the need for highly individualized instructor-student relationships. Since clinical rotations are such a major part of nursing education, a greater understanding of the relational process that occurs between themselves and their instructor would benefit all levels of nursing students.

Graduate Students

Graduate level nursing education courses will benefit from examining the implications of interpersonal boundaries. Graduate seminars would be an ideal forum to discuss boundaries and would also target nurses most likely to be educators. Because of the centrality of boundary issues to the unique nature of clinical instruction, exploring and internalizing a boundary conceptualization is pivotal to effective instruction and the development of a personal philosophy of teaching. This will result in the development of teaching styles that promote relationship and learning. Students entering graduate studies are typically keen to explore new ideas. The graduate forum may provide not only a place to discover and hone these boundary concepts, but also a place from which new proposals will emanate for further discussion and research.

Directions for Future Research

The interpersonal dynamics in the clinical nursing education context have not been studied in sufficient detail. While the current philosophical trend in nursing education seems to suggest and even impose a more connected learning environment, the mechanisms and consequences of greater connection implore further study. The majority of the techniques and practices utilized in clinical nursing education are borrowed from general nursing practice or from other disciplines. I propose that research specific to

nursing education would elucidate and value the uniqueness of the educational conditions in the clinical context. Throughout the process of the present study four areas of future research became immediately evident. These areas would contribute greatly to the understanding of the concept of boundaries in the instructor-student relationship.

Student Perspective

A critical direction for future research would be to gain students' perspective on how their boundaries are defined, constructed and influenced in the clinical relationship. I have noticed, through the process of the present study, that only a fractional amount of the literature on teaching and learning in nursing has incorporated the students' perspectives, despite much research being done examining how teaching ought to be done and how learning occurs. Acquiring the student perspective would reveal rich data regarding how instructors' and students' perspectives regarding boundaries are similar or different and how student perceptions surrounding boundaries affect the learning process.

I suspect that how students construct interpersonal boundaries with their instructors would be quite different from the results of this study. The pressure that students are under to perform and to measure up to evaluation criteria creates a tremendous burden and may hinder learning. For this reason alone, acquiring the student perspective is crucial.

Age, Educational Level and Culture of Students

Other potential research questions might examine how the age, educational level and culture of students affect the delineation of their boundaries. It is possible that students of different ages delineate their boundaries differently. For example, relatively young students may view student-instructor boundaries differently than mature students. As well, students at the beginning of the educational process may differ from students nearing graduation in their delineation of boundaries in the clinical relationship. Such a study could explore the link between student-instructor boundaries as they are influenced by increasing student independence. Due to an increasingly culturally diverse nursing student body an understanding of cultural beliefs is imperative. Cultural beliefs and values can have a profound impact on delineating and interpreting interpersonal boundaries and should be studied for greater understanding in clinical nursing education.

Correlation Between Connection and Self Disclosure

The correlation between connection and self disclosure seemed to be a reflection of the level of professional-personal interaction. It would be interesting to inquire into the nature of this potential link between self disclosure and level of connection. This would aid in illuminating the purpose and place of self disclosure in the clinical relationship.

Implementation and Embodiment of Interpersonal Boundaries

Another direction for future research might involve an examination of how clinical instructors implement and embody interpersonal boundaries in the clinical setting. The present study was not able to observe how instructors incorporate their boundary beliefs into their practice. An ethnographic approach, following and observing instructors as they interact with students, would be a fascinating and revelatory methodology. Such a study

would also contribute to greater precision in determining how interpersonal boundaries relate to the quality of the learning environment.

In summary, the definition and construction of instructor interpersonal boundaries can have a profound impact on the participants of the clinical relationship. The present study, although useful in examining one aspect of the clinical relationship, would do well to be augmented by further study from a variety of perspectives and participants. This would promote a broader comprehension of the process, nature and essence of the clinical educational relationship.

Summary of the Study

Both the literature and the results of this study confirm that interpersonal boundaries are an important topic of discussion and research. The literature review presented two primary views of interpersonal boundaries. One perspective advocated a distinct boundary between what was considered professional and personal. This view suggested that boundaries be maintained to provide protection against relationships that are too close or unethical. The opposing perspective considered boundaries to be hindrances to effective relationships. This perspective advocated that boundaries restricted relationships by causing divisions of hierarchy and rigidity.

The present study examined instructors' views of how they defined and constructed interpersonal boundaries with their students. The view that emerged from the data was that boundaries were limiting mechanisms but part of a normal relational process. Instructors' boundaries were constructed as an interplay between various levels of professional and personal interaction. The instructors' level of connection and amount of

self disclosure with students was the primary indication of their boundary definition and construction.

The discussion raised the issue of the difficulty that instructors have in defining what is professional and personal. What emerged was not a single distinct boundary that could not be crossed but a process of incremental boundary crossings. This construction presented boundaries as a normal relational process of boundary crossings and limits.

The examination of boundaries was a fascinating process. It was interesting to see how the concepts of boundaries, connection and self disclosure related. The study of these concepts gave me an increased understanding of how clinical instructors defined and constructed interpersonal boundaries with their students and the results of boundary delineation.

Boundaries are an important consideration in examining how instructors relate with their students. I believe that a better understanding of interpersonal boundaries will enhance the understanding of the clinical relationship by removing the pressure that exists to define a prescribed boundary of interaction. More research is necessary to better understand this critically important part of clinical teaching in nursing education.

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Appendix 1 Sample Letter of Permission

XXXX XXXXX

Director XXXXX School of Nursing

XXXXXXXXXX

Dear XXXX XXXXX:

I am a MSN student attending the UBC program. I am pursuing a research project for the purpose of my graduate thesis. I am interested in attracting nursing instructors from XXXXX as part of the participants in my study. I am writing you to ask permission to pursue XXXXX nursing instructors as research participants.

Enclosed is an invitation to participate in the research project. I would appreciate if this could be posted at an appropriate place at your school of nursing. I am interested in also approaching some instructors personally with an invitation to join. Please feel free to contact myself at: XXX-XXXX or by E-mail at XXX You may also contact my thesis supervisor Dr. XXXXX at XXXXX for additional information.

As part of the ethical review process at UBC I would require a letter from you giving me permission to solicit research participants from your school of nursing. If you could mail this to me I would greatly appreciate this.

Sincerely,

Mark Pijl Zieber RN, BN

Attachment

Appendix 2: Sample of Invitation to Participate

An Invitation to participate in a Nursing Research Study

My name is **Mark Zieber RN, BN** and I am attending UBC in the Masters of Science in Nursing program. I am conducting a research project for the purpose of my graduate thesis.

I am seeking research participants who are active in clinical nursing instruction and who have at least two years of teaching experience. Participants should be willing to give one to two hours of their time for one or possibly two taped interviews. The interviews would be held at a mutually agreeable time and place.

Summary of my thesis proposal:

Clinical nursing education is a relationally intensive process. An important consideration in the instructor-student relationship is the interpersonal boundaries between participants. These boundaries can determine the effectiveness of the learning environment as well as the quality of the learning experience for both the instructor and students. Current literature reflects a wide range of opinions of what constitutes an interpersonal boundary and its significance to nursing education. The purpose of this study is to examine clinical nursing instructors' perspectives of how interpersonal boundaries are defined and constructed in their teaching.

The research question is:

How do clinical nursing instructors define and construct interpersonal boundaries with students?

I am looking for four or five instructors from XXXXX School of Nursing to be participants. For more information please contact me at:

Telephone: XXXXXX (Home) **E-mail:** XXXXXXXX
 XXXXXX (Office)

You may also contact my thesis supervisor, Dr. XXXXXX, at XXX-XXXX or XXXXXX, for more information.

Thank you.

Mark Zieber RN, BN

Appendix 3: Sample Consent Letter

Informed Consent
for

**How Clinical Instructors Define and Construct Interpersonal
Boundaries with Students**

Principle Investigator: Carol Jillings RN, PhD
UBC School of Nursing
Telephone XXX-XXXX

Co-Investigator: Mark Zieber RN, BN
Student, MSN Program at UBC
For Graduate Thesis
Telephone XXX-XXXX

Purpose:

The purpose of this study is to examine the issue of interpersonal boundaries between clinical nursing instructors and students.

Study Procedures:

By participating you will be agreeing to be interviewed for approximately one hour. The Interview will be audio taped to allow for transcription. The data will be transcribed into a computer word processor file which will be password protected. The interview will be arranged at a mutually agreeable time and place for yourself and the researcher.

Analysis of the gathered data will utilize a process called naturalistic inquiry, an interpretive qualitative methodology.

Confidentiality:

Any information resulting from this research will be kept strictly confidential. All documents will be identified by only a code number and kept in a secure location. Participants will not be identified by name in any reports of the completed study. Computer data records will be maintained only by the co-investigator. Once the analysis procedure is complete the data audio-tapes will be destroyed.

Contact:

If you have any questions or desire further information with respect to this study, you may call **Dr. Carol Jillings (Supervisor) at XXX-XXXX** or **Professor Elaine Carty (Committee member) at XXX-XXXX**.

If you have any concerns about your treatment or rights as a research participant you may contact Dr. Richard Spratley, Director of Research Services at UBC, at XXX-XXXX

Consent:

I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from this study at any time without jeopardy or record of any contact.

I have received a copy of this consent form for my own records

I consent to participate in this study.

Participant Signature

Date

Signature of witness

Date