Boundaries, Hospice and Rural Communities: Social Workers’ Perspective

Haylee Erin Spronk
University of St. Thomas, Minnesota

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Boundaries, Hospice and Rural Communities: Social Workers’ Perspective

by
Haylee Erin Spronk B.S.W, L.S.W

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

Committee Members
Kari Fletcher, Ph.D., LICSW(Chair)
Dawn Eckhoff, MSW, CSW-PIP
Pam Neet, BSW, LSW

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

In the past years, the utilization of hospice has increased greatly from previous years and is expected to only increase. This increase is not only found in urban communities but in rural communities as well. Previous research exemplifies that professional boundaries can be different in rural communities than in urban communities. This research set out to explore how rural hospice social workers maintain professional boundaries through eight (n=8) semi-structured interviews. The findings, developed through an open-coding process, included the following themes: the rural community and the grocery store experience, maintaining professional boundaries, and methods to helping professional boundaries. These themes aligned with previous research but participants added depth and understanding to the limited research. More research needs to be performed in the area of rural hospice social work as professionals are left with very little guidelines.
Acknowledgments

First, I would like to thank my Lord and Savior Jesus Christ for upholding me through this research process. He surrounded me and gave me strength when I felt overwhelmed by the process and peace when I doubted. He surrounded me with such an amazing support system of family and friends to help me and give me encouragement when I needed it most. My husband and family gave me words of encouragement and reminded me constantly of why I wanted to do this. I would also like to thank the participants in this study for their willingness to participate in this study. Their knowledge and excitement about their work was uplifting and so teaching to me I just cannot give you enough credit for what you do. Thank-you also to Kari Fletcher for guiding me through this process and offering me a calming presence when I myself did not feel calm at all. Thank-you also to my committee for giving me great suggestions and for walking with me during this research process. It almost feels like this project is not a result of anything that I myself could do but each sentence is graced by an important presence that influenced me to write it: a word of encouragement, a prayer, a husband taking care of kids, a grandma giving me time to write, a friend reminding to push on, a person correcting all my errors, a committee to offer suggestions, and a verse to not worry about tomorrow. All I can say is: Thank-you!
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Boundaries, Hospice, and Rural Communities: Social Workers’ Perspectives

Introduction

Today’s elderly population, 65 years and older, in the United States has tripled since the 1900’s (Administration on Aging [AOA], 2013). As the baby boomers age, this growth is projected to continue in the next 30 years. In the 1900’s, the elderly population represented just 4.1% of the general population and in 2000, the Administration of Aging estimated there was 35 million elderly or 12.4% of the general population 65 years or older in United States. In 2011, that number grew to 41.4 million elderly or 13.3% of the population and by the year 2040, the number is expected to increase to 79.7 million elderly accounting for 21% of the population. With the increase in elderly population, the number of people over 85 has also increased. From 1900 to 2010, the centurion population has grown 66% and it is estimated people turning 65 can live on average another 19.2 years which will create stress on the current infrastructure of agencies serving the aging population (AOA, 2013).

Within rural communities, elderly populations are expanding at rates disproportionate to other age groups, which present challenges in serving this population. Currently, due to the out migration of younger workers, the rural community contains a larger percentage of the aging population (Averill, 2003). Approximately 7.5 million elderly live in a rural area which equates to 15% of the rural population being composed of the 65 years or older as compared to 13.3% of the general population (National Advisory Committee on Rural Health and Human Services [NACRHHS], 2008). The rural community faces a number of age-related difficulties, one of which is the rural poverty level. Rural poverty level is a concern due to the higher rate of 16.5% of the
population being impoverished poverty while the general population remains at 13.5% (United States Department of Agriculture [USDA], 2011). Along with the higher poverty rate, elderly in the rural communities experience a lack of transportation, medical care, social services, and adequate housing (Rural Assistance Center [RAC], 2012). Due to increased poverty and less resources, rural elderly are considered more vulnerable than the elderly who live in urban communities (RAC, 2012; USDA, 2011).

Not only are elderly living in rural communities faced with challenges, professionals must also navigate challenges continuously. The recruitment of professionals to rural areas is difficult and as a result creates higher workloads, less available supervision, and the need to perform generalist practices among providers who do work in rural areas (Averill, 2003; Cambell, Merwin, & Yan, 2009; Haxton & Boelk 2010; Waldrop & Kirkendall, 2010). Even when professionals are recruited to the community, they feel that their education has left them unprepared for working in remote settings (Haxton & Boelk, 2010; Robinson, Pesut, Bottorff, Mowry, Broughton, & Fyles, 2009). Professionals also struggle with professional boundaries between professional and personal life, dual relationships, limited supervision, continuing education options within a reasonable distance, professional isolation, and long distances to see clients (Haxton & Boelk, 2010; Robinson et al., 2009).

While professionals work with challenges in the rural community, studies show 80% of the American population would like to die in their own homes (Virnig, Haijun, Hartman, Moscovice, & Carlin, 2006). Even though many people prefer to die at home, 60% of the elderly population still dies in an institution such as a hospital or long-term care facility (Center for Disease Control and Prevention [CDC], 2010). In 2007, one
fourth of the elderly population died in their own home which is a slight increase from one sixth of the elderly population over the last decade (CDC, 2010). Interestingly, elderly patients in a rural community are more likely to die in an institution when compared to elderly patients in the urban community (Temkin-Greener, Zheng, & Mukamel, 2012).

Hospice programs were created to allow patients to die in their “home” wherever that might be and provide comfort care at the end-of-life. Even though these programs were established more than 40 years ago in the United States, they have grown immensely in the last 13 years (National Hospice and Palliative Care Organization [NHPCO], 2012). In 2001, just 18.8% of Medicare recipients utilized the hospice program (NHPCO, 2012). By 2007, the percentage increased to 30.1% of recipients utilizing the program, and by 2011, 43.3% or 1.65 million of Medicare recipients are estimated to utilized the program (NHPCO, 2012). It is estimated in 2011, 44.6% of all deaths will be under the care of hospice (NHPCO, 2012). As the need for hospice increases, so will the need for professionals to serve in hospice programs (Reese, 2011).

In contrast to national hospice service utilization rates, hospice services in rural communities are underutilized. Statistics show 15.2% of rural participants’ utilized hospice at the end-of-life while 22.9% of urban participants utilized the hospice benefit (Waldrop & Kirkendall, 2010). Statistics show a 100% of the urban population is served by a hospice while just 24% of rural areas not adjacent to an urban area lack hospice services (Virnig et al., 2006). Many more challenges are confronted by rural hospices as these programs need to cover a large geographical area, have less access to available services, contend difficulties obtaining professionals, and experience financial burdens.
(Hospice Information Center, 2013). Professionals working within rural hospices endure lack of education of hospice services both from other professionals and potential patients and the population fears utilizing a program that might hasten death which create barriers to using services (Waldrop & Kirkendall, 2010).

Both rural and urban hospice programs are configured to support the patients, families, and caregivers at the end-of-life with an interdisciplinary team approach that includes physicians, nurses, social workers, and volunteers (NHPCO, 2012). Within a team-based approach, social workers are providers of psychosocial needs for end-of-life patients and their families. Social Workers are in the front line of dealing with death and dying within the ever expanding world of end-of-life care (Gutheil & Heyman, 2011; Oliver, Washington, Demiris, Wittenberg-Lyles, & Novak, 2012; Reese, 2011). Education, emotional support, bereavement, and psychosocial supports are examples of services provided by social workers that serve end-of-life patients and their families (Reese, 2011).

An important part of the hospice social worker’s position is establishing a relationship with the family and patient (Sanders, Bullock, & Broussard, 2012). This relationship can become a very close and emotional relationship which can lead to boundary issues (Sanders et al., 2012). Rural hospice social workers experience boundary issues not only with emotional relationships, but also within the rural community (Cohn & Hastings, 2013; Curtin & Hargrove, 2010) Social workers in the rural community experience increased boundary issues compared to their urban counterparts due to rural communities being smaller and members fulfilling multiple roles in the community (Cohn & Hastings, 2013; Curtin & Hargrove, 2010). The purpose of this study is to
explore how rural hospice social workers approach the boundary issues that they encounter especially nonsexual dual relationships both in hospice and the rural community they practice.
Literature Review

In order to better understand the information present in the literature review, key terms and definitions need to be established. Definitions for the following terms will be addressed: rural, end-of-life care, palliative care, hospice care, boundaries, dual relationships, boundary violation, and boundary breach.

The first definition is for the term “rural.” For the purposes of this study, the definition of the Office of Management and Budget (OMB) will be used. This term is defined later under the rural definition section. This definition is utilized due to majority of the literature adopting it and also the definition fits the current place of this study. The terms end-of-life care, palliative care, and hospice care will be used throughout the literature review. The term end-of-life care encompasses the life phase of a person who has a terminal, incurable disease and the care that they receive. Both hospice and palliative care occur under this overarching definition. This life phase can be weeks, months, or even years (McGuire, Grant, & Park, 2012). The term palliative care is best defined by the “Get Palliative Care” website (2012) which states the following: “Palliative care is specialized medical care for people with serious illnesses. It focuses on providing patients with relief from symptoms, pain, and stress of serious illness—whatever the diagnosis. The goal is to provide quality of life for both the patient and family.” The final definition is hospice care which is a not a place but an approach to care. It requires a team process to providing comfort, dignity, and management of symptoms at the end-of-life. A physician is required to certify that a person is terminal and has six months or less to live; however, if certain criteria are met, person can live beyond those six months and still continue to use hospice services (NHPCO, 2012).
The exploration of the term *boundary* is necessary for the literature review. According to Barker, *boundaries* refer to *regions separating two psychological or social systems* (Barker, 1999). These *boundaries* in social work are between the social worker and the clientele they serve. Boundaries create a safe place for the relationship to take place (Strom-Gottfried, 1999). Within the boundaries that social workers create, the idea of dual relationship enters. *Dual relationships or multiple relationships* occur when *professionals engage with clients or colleagues in more than one relationship, whether social, sexual, religious, or business* (Reamer, 2003 p. 121). *Boundary breach* is a breach of boundaries that is unintentional or understandable given the circumstances (Davidson, 2005; Strom-Gottfried, 1999). Lastly, a *boundary violation* is best explained by “a more serious action which a professional uses the relationship with the client to meet their personal need at the expense of the client, and this is never justifiable” (Davidson, 2005, p. 519).

**Rural Definition**

Since the disparities of poverty in the rural community have been documented as stated in the introduction, research has begun to emphasize this unique population (Blieszner, Roberto, & Sing, 2001; Cohn & Hastings, 2013; Goins, Kategile, & Dudley, 2001). Much of the literature available on rural communities focuses on the weakness of the communities such as the lack of access to health services and mental health services, as well as difficulty in the recruitment of professionals, inadequate transportation, and weak formal support systems (Alexy & Belcher, 1997; Cohn & Hastings, 2013; Patrick, Cottrell, & Barnes, 2001). Yet interestingly, a common definition of the word “rural” has not been reached (Waldrop & Kirkendall, 2010).
Within research, differing definitions of the word “rural” have been utilized to perform research in the rural areas (Keating, Swindle, & Fletcher, 2011; Nofz, 1986; Waldrop & Kirkendall, 2010). A majority of articles center on three main definitions from: (1) The Office of Management and Budget (OMB); (2) The U.S Census Bureau; and, (3) The U.S Department of Agriculture. The OMB’s definition is the most commonly used definition for rural (Nofz, 1986; Waldrop & Kirkendall, 2010). The method used by the OMB to define rural, designates counties into Metropolitan which is a population of 50,000 or more people, Micropolitan which is less than 50,000 but more than 10,000 people in the population, and Neither which is all other counties that do not fit into one of these categories. The definition of rural from the OMB than includes the Micropolitan and Neither classifications for counties. The limitation to this way of defining rural is that barren areas within Metropolitan counties are still considered Metropolitan rather than rural (HRSA, 2013). The U.S Census Bureau does not explicitly define “rural,” but has a similar three categories for defining areas. An Urbanized Area (UAs) is more than 50,000 people while Urban Clusters (UCs) are at least 2,500 people, but less than 50,000 people. The areas that do not fall in these categories are considered “rural” for the purposes of research. The limitation with this form is that the areas do not follow city or county lines (HRSA, 2013). The third definition of “rural” comes from the Economic Research Service of the U.S Department of Agriculture, which divides areas into regions based on population density then “rural” is defined as open counties or settlements with less than 2,500 people (Waldrop & Kirkendall, 2010). These main definitions can be seen in Table 1.
Table 1

Definitions of What Constitutes “Rural” by Government Agencies

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition of Rural</th>
<th>Area Covered</th>
<th>Benefits</th>
<th>Challenges</th>
</tr>
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<tr>
<td>Office of Management and Budget</td>
<td>Counties with Less than 50,000 people considered “nonmetro” or “neither”</td>
<td>Designated by counties</td>
<td>Easy to define counties</td>
<td>Some counties may have been designated “metro” but contain rural towns.</td>
</tr>
<tr>
<td>U.S Census Bureau</td>
<td>Open countries and settlements with less than 2,500 people</td>
<td>Divided by population size and density</td>
<td>More stringent definition</td>
<td>Very difficult to define specific areas</td>
</tr>
<tr>
<td>U.S Department of Agriculture</td>
<td>Open counties and settlements with less than 2,500 people</td>
<td>Divides into core-based statistical areas based on population density and counties</td>
<td>Covers counties and population density</td>
<td>Utilize differing definitions based on rural program eligibility</td>
</tr>
</tbody>
</table>


Although three main definitions of rural are utilized in research, other articles apply their own definitions of rural areas. In the study by Averill (2003), a county being researched was designated rural due to the largest town having a population of 10,545 and several other towns with only hundreds of people. The research article by Sun (2011) utilized the Alabama Rural Health Association’s (ARHA) definition for rural which contains four factors: total percentage of population employed by the public school system, dollars of agriculture per mile, population per square mile of land, and populations of largest cities in the county. Canadian researchers utilize “Canada’s ‘rural and small town’ definition, which incorporates populations living in towns outside the commuting zones of centres (centers) with a population of 10,000 or more” (Keating, Swindle, & Fletcher, 2011, p. 327). Even if there were a common definition of rural,
these communities still hold unique characteristics that may not be defined by any one definition (Keating et al., 2011).

**Boundaries in Social Work**

Similar to the differences of rural definitions, professional boundaries has exhibited much debate in the field of social work over time as well (Davidson, 2005). Social workers debate about the nature of dual relationships and how much self-disclosure is helpful to clients (Curtin & Hargrove, 2010; Davidson, 2005; Halverson & Brownlee, 2010). The ever-changing nature of professional boundaries can be seen in the National Association of Social Worker’s (NASW) *Code of Ethics*.

Boundary issues are addressed by the United States National Association of Social Worker’s (NASW) *Code of Ethics*. The *Code of Ethics* began addressing this issue in 1979 by discussing the nature of sexual relationships of social workers with clients as absolutely unethical. The NASW again looked at the concept of dual relationships in 1993 stating strongly the importance of not engaging in dual or multiple relationships with present or past clients especially when it may cause harm to the client or exploitation of the relationship (NASW, 1993). The NASW *Code of Ethics* felt that a stronger emphasis needed to be placed on this issue of boundaries and addressed the area again in 1996 because researched showed that issues related to boundaries were one of the main reasons litigation was brought against social workers (Strom-Gottfried, 1999). The code worked to clear gray areas in dual relationships by stating that a social worker engaging in a relationship with a client other than professional, whether current or past, is considered a breach of the *Code of Ethics* (Davidson, 2005). The code not only addresses dual or multiple relationships but also sexual relationships, and appropriate physical
contact. Breaches of the code can be reviewed and corrective action can be taken by NASW (NASW, 1999).

Currently, practitioners lack consensus about boundaries, especially the nature of dual relationships (Borys & Pope, 1989; Reamer, 2003; Strom-Gottfried, 1999). Although the Code of Ethics takes a strong stand on not engaging in dual relationships if possible, practitioners argue that it is not always possible to mind boundaries, especially within rural settings (Reamer, 2003; Davidson, 2005). Some authors suggest a continuum of dual relationships between entangled relationships and rigid boundaries with practitioners trying to find a balance between the types of boundaries (Davidson, 2005; Reamer, 2003). While the article by Kagle and Grielhausen (1994), argues that dual relationships are never ethical. Reamer (2003) suggests that dual relationships can be categorized into five central themes: intimate relationships, personal benefit, emotional and dependency needs, altruistic gestures, and unanticipated gestures. Overall, the articles agree education needs to be given about boundaries especially on dual relationships (Borys & Pope; Strom-Gottfriend, 1999; Reamer, 2003; Davidson, 2005; Kagle & Giebelhausen, 1994).

Providing education on dual relationships has been a strain in the social work curriculum (Congress, 2001). In the study conducted by Congress (2001) exploring dual relationships within the university setting, only 18.5% of schools surveyed reported a mandatory class on ethics and only 34.5% of schools surveyed have a policy on dual relationships. The researcher suggests that this only further grays the area of boundaries in social work (Congress, 2001). A few authors have made recommendations for curriculum including Reamer (2003) who states that boundary violations happen when
they: (1) interfere with exercise of profession discretions; (2) interfere with impartial judgments; (3) exploit clients, colleagues, or third parties to further own interests; and, (4) harm clients, colleagues, or their parties (p.129). While Davidson (2005) suggests a curriculum should include (1) the “Professional Relationship Boundaries Continuum” conceptual framework; (2) boundary violation impact; (3) personal boundary vulnerabilities; (4) blurring boundaries indicators; and, (5) risk minimizing strategies (Davidson, 2005). The format should be utilized in lecture, dyad, individual work, and large group activities (Davidson, 2005).

There is an importance of educating future social workers on these issues because these violations are costly for social workers (Reamer, 2003; Strom-Gottfried, 1999). In a study by Strom-Gottfried (1999), 56.1% of ethics violations addressed by NASW were related to boundary issues including sexual relationships, dual relationships, and poor clinical practices. Of the boundary violations, 36% were a dual relationship relating to social relationships followed by 11.5% in business relationships. The violations were divided into only two categories: boundary violations and non-boundary violations. Of the social workers committing boundary violations, 59% were males and 41% were female and a majority had a Masters of Social Work. Generally, boundary violations occurred more frequently in private practice settings than in agency settings and males were more likely to commit sexual violations than females (Strom-Gottfried, 1999).

Boland and Prom (2009) more recently conducted a study on social work violations similar to above study. Previous research examined NASW ethic violation proceedings, but this study investigated license sanctioning within the 50 states. Violations were divided into more specific categories than previous research. The results
were consistent with previous research, dual relationships comprised a majority of violations at 23.4%, a majority of respondents had a graduate degree, and males were disproportionately represented in sanctioned social work proceedings. The study also focused on state sanctioning processes and how they differ greatly from state to state (Boland-Prom, 2009).

Several studies have looked at the concept of boundaries as they relate to dual or multiple nonsexual relationships and the views of mental health practitioners. Borys and Pope (1989) in a national study of psychologists, psychiatrists, and social workers who self-reported professional boundaries had similar results as the violation studies. Private practitioner respondents, rural respondents, and male respondents tended to view dual involvement as more ethical than their counterparts and psychodynamic respondents viewed the same factors less ethical than other theoretical orientation. (Borys & Pope, 1989).

In another study Kitson and Sperlinger (2007) performed in the United Kingdom with 424 psychologists, they also looked at dual relationships between therapist and clients. Results showed those who view dual relationships as unprofessional were female, younger, recently qualified, and of the psychodynamic orientation. They also tended to work in an urban setting, and they did not live and work in the same area as their client, which is similar to previous findings. The research also explored the impact of supervision on beliefs of dual relationships; the results showed a person who received more supervision, rated supervision as more adequate, and experienced personal therapy viewed dual relationships as more unethical (Kitson & Sperlinger, 2007).
In another study conducted by Ringstad (2008) of Licensed Clinical Social Workers (LCSWs) and Marriage and Family therapists (MFTs) performed in the state of California, there was lower rates of practitioners engaging in dual relationships and no differences found between rural and urban settings. It also found males and females engaging in equal amounts of dual relationships, and practice setting not being significant, which was in contrast to previous research. Although the study did find respondents who belonged to a professional association engaged in less dual relationships than those who did not belong to an association (Ringstad, 2008).

Overall, the studies agreed on several key points. Most mental health practitioners felt receiving a gift less than $10 was ethical under most circumstances and happened the most frequently (Borys & Pope, 1989; Kitson & Sperlinger, 2007; Ringstad, 2008). On the other hand, sexual relationship with clients was the most agreed upon violation of boundaries followed by financial or business involvement with a client as the next top violations (Borys & Pope, 1989; Kitson & Sperlinger, 2007; Ringstad, 2008). Along with these two agreed upon factors, several studies agreed boundaries within a rural community were different than an urban community (Borys & Pope, 1989; Gillespie & Redivo; 2012; Helbrok, Marinelli, & Walls, 2006; Kitson & Sperlinger, 2007).

**Boundaries in Rural Communities**

A few studies have touched on the differences in boundaries in the rural community versus an urban community. The rural community often focuses on independence and has as overall distrust of “outsiders” (Nickel, 2004). Practitioners are also more likely to experience clients outside of the professional-client relationships given the communities are smaller (Borys & Pope, 1989; Cohn & Hastings, 2013;
Halverson & Brownlee, 2010; Pugh, 2007). People within rural communities often have to engage in multiple roles to fill all the needs within their communities (Cohn & Hastings, 2013; Halverson & Brownlee, 2010; Nickel, 2004). Many of the studies are qualitative in nature but focus on dual relationships, professional visibility, confidentiality, and benefits dual relationships within the rural community.

In a study by Helbok, Marinelli, and Walls (2006), the researchers performed a comparison of ethical practices between rural and urban communities through national surveys. These researchers found rural practitioners encounter more ethical issues and dual relationships than urban practitioners do. These encounters follow a spectrum from incidental contacts to providing therapy to a social contact. The report qualitatively discussed how therapists often feel uncomfortable by these incidental contacts as they feel that all eyes are on them. Rural practitioners reported they feel like a therapist 24-hours a day. The findings are similar to the mixed method study of Gillespie and Redivo (2012) in which respondents felt they were always under a microscope by community members. The article by Cohn and Hastings (2013) also reported how respondents often felt they were never “off-duty.” The study by Borys and Pope (1989) established that rural practitioners felt that dual relationships were more ethical than their urban counterparts.

Along with professional visibility, the topic of confidentiality was also addressed in research. In Cohn and Hastings (2013) theoretical article, it was discussed that confidentiality can also be an issue for rural practitioners as community members typically know more about one another. While Pugh’s theoretical article (2006) discusses that challenges of confidentiality is unavoidable but practitioners are able to handle these
difficulties. In the research performed by Helbok et al. (2006), there appeared to be no difference in issues about confidentiality between rural and urban practitioners.

The concept of “outsiders” may affect professionals practicing within the community (Cohn & Hastings, 2013; Curtin & Hargrove, 2010; Gillespie & Redivo, 2012). In the theoretical article by Cohn and Hasting (2013), the importance of family ties within a community were strongly emphasized so when people left their communities to seek education they are considered “outsiders” and could not be trusted. Community members often establish credibility through family names, which requires more self-disclosure on the part of the practitioner (Cohn & Hastings, 2013; Pugh, 2006).

According to another article if a practitioner has practiced in a rural community or previously lived in the community, they increase the likelihood to enjoy working in the rural community and have greater chances of being accepted into the community (Gillespie & Redivo, 2012).

Another factor to consider in rural communities is the type of professional role the practitioner engages in within community (Halverson & Brownlee, 2010). Halverson and Browlee (2010) qualitatively studied rural communities in Canada through interviewees. Results showed that the type of employment affected the effectiveness of a dual relationship. If a social worker was providing education, the dual relationship was less uncomfortable where as if the social worker was a child abuse investigator the dual relationship was less manageable. Pugh (2006) also considered the type of relationship and found practitioners employed in child protection, mental health, or domestic violence, were more likely to face social isolation and pressure.
Even though many studies have focused on the challenges of dual relationships, studies have also looked at the benefits of dual relationships within a rural community (Cohn & Hastings, 2013; Nickel, 2004; Curtin & Hargrove, 2010; Halverson & Brownlee, 2010). One qualitative study found in a rural Canadian communities that the worker who was closest to the client took on the case. They perceived this as a benefit because the worker already knew the family, was in their “circle of trust,” and was able to quickly accommodate to the case (Halverson & Brownlee, 2010). In the article by Pugh (2006) considering dual relationships in rural communities in the United Kingdom, found dual relationships had a way of “humanizing” the relationship between client and worker and minimizing the power dynamic in the relationship.

**Strengths of the Rural Community**

Although much of the research is problem-focused as it relates to rural communities, a few studies have attempted to conceptualize the strengths of this population. A few studies briefly touch on strengths of the rural community stating how this population utilizes more informal support systems, take care of their own, utilizes creativity in problem solving, family is more involved in care, people are involved in more activities in the community, and people have a strong sense of religiosity (Averill, 2003; Cohn & Hastings, 2013; Haxton & Boelk, 2010; Hicks, Patrick, et al., 2001; Jenkins & Cook, 1981; Keating et al., 2011).

A few specific studies have addressed strengths in rural communities in a qualitative manner, one study by Haxton and Boelk (2010) found that professionals perceived enjoying the challenge of rural hospice work. Professionals utilized creative solutions, utilized word of mouth methods for education, used unique solutions to formal
and informal support gaps in elderly care, stressed importance of team work, and collaborated with many different professionals. The article by Cohn and Hasting (2013) on rural practice discussed how rural practitioners reported flexibility, freedom, and autonomy of this population. They also enjoyed “meaningful collaboration” with other practitioners, professional visibility, and overall job satisfaction. Averill’s study (2003) relating to strengths of the rural community in New Mexico, resulted in that specific community having strength in a very diverse and culturally rich community which was very involved in the human experience of the community members. The research also already had professionals working within the community to provide education to its members about health related issues and they had a committee working on the future of the county. Although a few studies emphasize strengths of the rural community, they are typically qualitative in nature and have a very limited nature of measuring the strengths of the rural community (Keating et al., 2011).

**Boundaries in Hospice**

Very little research has been done on the topic of boundaries within hospice practice, especially as it relates to rural practitioners (Haxton & Boelk, 2010; Sanders, Bullock, & Broussard, 2012). In a mixed methods research article concerning rural hospice social work, lack of anonymity as a professional and dealing with knowing the patient outside the professional relationships were considered challenges for all respondents who practiced majority in rural communities yet very few studies address this in the hospice realm (Haxton & Boelk, 2010).

In a qualitative article by Sanders, Bullock, and Broussard (2012), the article focuses on professional boundaries in hospice and found that often deep relationships are
formed during the delivery of end-of-life care. The article identified a theme “we are family,” in which a case study showed a social worker who begins to over involve herself in a case giving her personal cell phone number and visiting the family much more frequently than other patients. Interestingly, Claxton-Oldfield, Gibbon, Schmidt-Chamberlain’s article exploring boundaries in end-of-life volunteers also reported this same theme of “we are family,” however, volunteers have a different role than other professionals as they balance between friend and a professional role (Claxton-Oldfield, Gibbon, & Schmidt-Chamberlain, 2011).

The article on social work boundaries in hospice goes on to identify “over-identification” as another theme which encompassed sub-themes of “professional judgment and neutrality.” “Over-identification” is when a professional over identifies with a client and it compromises their professional judgment and decisions that are made. “Self-disclosure” was another boundary issue that was a sub-theme identified and the article discusses how self-disclosure in hospice can be either beneficial or detrimental to the working relationship. The final theme identified was “going over and beyond” where professionals were doing things above and beyond what they normally would do for every client such as giving out personal numbers, giving personal items such as books, and picking up items on the way to the house (Sanders et al., 2012). Many of these themes coincide with themes that occur in the rural community.

Articles have explored professional boundaries in therapist and a few have explored boundaries within the rural and urban communities. Overall the articles disagree on the proper use of professional boundaries. The literature shows boundaries are unique within a rural community given the hesitance to outsiders, sense of independence and
overall need for dual relationships to fulfill roles within the community. Boundaries are also of concern within hospice as the practice is emotionally charged and strong attachments are made between client and worker. Given the boundary issues within rural community and strong attachments made within hospice, the rural hospice social worker walks a fine line with boundaries without research in their given area to guide them through ethical concerns.
Conceptual Framework

Theoretical Lens

A relationship is a state in which two objects of in this case people are connected (Barker, 1999). The relationship between a social worker and client is the basis for accomplishing work between the two people (Davidson, 2004). This relationship is shaped by the outside context or systems each person is a part of (Davidson, 2004). In order to understand professional boundaries and how they relate to hospice social workers and the rural community, two frameworks of Ecological Systems theory and Professional Boundaries Continuum will be addressed. As seen through the literature review, the context of hospice and rural practice shape how professional boundaries are formed.

Ecological Systems Theory. The framework for this study is influenced by the ecological systems theory first presented by Bonfenbrenner. This framework allows for the professional to be viewed in context of their interactions between differing systems which include: micro-, mezzo-, exo- and macro- systems (Bonfenbrenner, 1994). Each of these systems impact a professional’s view of boundaries and the relationship between the different systems is reciprocal in nature. The system of hospice and rural communities influence a professional’s view of professional boundaries.

The ecological systems theory by Bonfenbrenner (1994) pursued that an individual cannot be viewed simply as an individual but a person influenced by different systems. These systems impact the individual and the individual impacts the systems. These forms of immediate and lasting impact happen through proximal processes, which
are interactions that occur on a fairly frequent basis as a parent-child relationship. These processes have the greatest effect on the individual. Bonfenbrenner also considers outside influences such as a parent’s workplace can also influence the relationship. In order to better understand these systems, they will be explored in the context of professional’s boundaries in the rural context in the micro-, mezzo-, exo-, and macro-systems.

**Microsystems.** The micro system is defined as:

>a pattern of activities, social roles, and interpersonal relationships as experienced by the developing person in given face to face interaction setting with a particular physical, social, and symbolic features that invite, permit, inhibit engagement in sustained progressively more complex with activity in the immediate environment (Bonfenbrenner, 1994, p. 39).

Microsystems can include the client-professional relationship and also the effect of the family on the professional’s life. If a professional’s family has very rigid boundaries regarding physical touch, the professional may struggle with a family’s more entangled boundaries regarding physical touch as they give the professional physical contact. Professional boundaries are impacted by the type of relationship that the social worker forms with a client which is very emotional as seen through the literature review. As the relationship becomes more emotional, the professional’s ability to see boundaries may become blurred.

**Mezzo systems.** The mezzo systems are the interactions between a series of microsystems. It is the relationship between two systems such as work and school or home and work (Bonfenbrenner, 1994). For example, when a professional works in rural hospice, his home life may impact her professional reputation. For example, when a professional goes through a difficult divorce and this becomes common knowledge among members of tight-knit community, a hospice client may request that the
professional not work with him due to the professional’s current family situation. The impact of mezzo systems influences how a professional practices in the rural community.

**Exo systems.** *Exo systems* are a connection between two or more systems that may not directly impact the professional (Bonfenbrenner, 1994). To illustrate what an exo system looks like in a rural community the following example is given: A professional is currently working in a hospice agency ran by the local hospital. The hospital has recently had many budget issues but hospice program continues to be financially stable. The professional is impacted by the hospital’s budget issues as clients question the stability of the hospice and the professional must decide how much information to share with clients about the hospital’s current situation. Professional boundaries are influenced by not only client relationships, but also the agencies they serve.

**Macro systems.** *Macro systems* are the views of beliefs of a culture containing the varying systems previously mentioned (Bonfenbrenner, 1994). The rural community would be considered one of the macro systems which can influence a professional’s view on boundaries. For example, a rural community requires a professional to self-disclose family relations in order to be considered part of the community. A social worker who previously worked in an urban community feels that this type of self-disclosure is not necessary and chooses not to disclose. The client then feels offended the social worker is unwilling to disclose and will not engage fully with the social worker. A rural community may have more entangled boundaries which can impact a professional’s need for rigid boundaries. The professional may have to adjust views on boundaries in order to adjust to the culture and environment of the rural community.
According to the ecological systems theory, a professional is engaged with varying systems and the systems are engaging with the professional. The systems include micro-, mezzo-, exo-, and macro- systems (Bonfenbrenner, 1994). Each of these can influence a professional’s view of boundaries and may impact how they attend to clients they serve especially within the hospice and rural contexts.

**Professional Boundaries Continuum Theory.** As addressed earlier, the “professional boundaries continuum” is not a new concept and was actually suggested by previous authors (Reamer, 2003; Strom-Gottfried, 1999). The idea behind the theory is boundaries exist not on a black and white schema, but on a continuum in which a practitioner moves through depending on the situation. On one end of the continuum the category of *entangled* and on other end is the category of *rigid*. Between the two ends of the spectrum is the term *balanced*. *Balanced* is where a practitioner would essentially like to be but as a practitioner enters closer to either end of the spectrum boundary breach happens and if the practitioner gets to the end of the spectrum boundary violations happen. See *figure 1.*

In order to better understand these terms definitions will be provided. The terms boundary violation and boundary breach have been previously defined. As defined by Davidson (2004), “‘entangled’ professional boundaries refers to consistent over-involvement” (p. 518). An example of this type of relationship is a social worker who gives personal cell phone numbers to clients, leaves personal items, and picks up items on their way just for that client (Sanders et al., 2012). This may be more common in rural areas due to lack of resources available, especially transportation, home health services, and long distances between clients. It would also be a good definition to describe social worker’s involved in hospice “going above and beyond” their normal scope of duty (Sanders et al., 2012).

Along with entangled definition, the word rigid also needs to be defined. Rigid is defined as “workers with ‘rigid’ professional boundaries barrel ahead with their own agenda inflexibility, condescendingly, and without attending to the unique and multifaceted needs of their client” (Davidson, 2004, p. 519). An example of this would be a social worker who is unwilling to define herself to a rural community member when rural community relies on understanding family connections in order to establish the social worker’s credibility. The social worker needs to take into consideration the unique culture of the rural community which may require less rigid boundaries. The final definition is balanced which is defined by Davidson (2004):

Workers with ‘balanced’ boundaries are authentic and caring while maintaining clear boundaries. They use their authority appropriately; remaining aware of their position of power, they take care to neither exploit their clients’ vulnerabilities nor infringe on their rights. Those functioning in a ‘balanced’ manner use profession judgment and self-reflection skills in their assessments and make decisions that are professionally responsible and accountable to other professionals (p. 519).
All practitioners function on a continuum between these types of relationships with clients.

Davidson also argues the “professional boundaries continuum theory” is not meant to put practitioners in a box but is meant to understand their decision making process at the time. A practitioner may have a tendency to one end of the spectrum versus the other end but in their decision-making process will over compensate for their tendency. For example, a practitioner may have a tendency towards certain entangled relationships due to her past history and is able to recognize this. The practitioner receives a case of a young mother recently on hospice and the practitioner is also a young mother. In order to over-compensate for her tendency for entangled relationships, she has more rigid boundaries with the client. The spectrum would put her decision of rigid boundary on the spectrum versus her tendency towards entangled. It is intended to show a practitioner’s actions concerning boundaries and not their decision making process (Davidson, 2004).

Certain areas of social work may require different boundaries (Reamer, 2003; Davidson, 2004; Strom-Gottfried, 1989). An example of this would be a child abuse worker who while investigating an allegation may have very rigid boundaries during the investigation in order to remain professionally neutral. A social worker who works in a rural community may need to disclose personal information in order to be accepted by the community which would create more entangled relationships. A social worker needs to have a degree of flexibility when assessing the need for boundaries due to cultural considerations and personal tendencies (Davidson, 2004).
Professional Lens

As Bonfenbrenner (1994) reports a person is influenced by a system and the system is influenced by the person; I am no different. I feel my Bachelor’s Degree in Social Work has influenced this project along with my work with hospice in the following positions: volunteer, home health aide, volunteer coordinator, and social worker. I have seen how professional boundaries within hospice can either positively impact a client or be detrimental to the relationship. Within the different roles in hospice each has their own unique challenges to professional boundaries.

I have also been a professional within a rural community for a short amount of time which has also formed this project. Before working in the rural community, I previously worked in an urban environment and noticed the change in professional boundaries needed in the rural community. While working in an urban community, very few families and clients asked for my last name, but while working in the rural community, my last name was a potential gateway to establishing rapport with clients and families.

Personal Lens

Along with my professional lens, my personal lens also needs to be considered. A person is shaped by the family and community they come from. I grew up in a rural community which has placed a desire to invest in these unique communities. Much of the research has focused on the negative of the rural communities, but yet these communities continue to exist. The topic for the paper was also shaped by personal experience with boundary issues and seeing the negative consequences of always pushing those boundaries.
This project is written as a result of a Master of Social Work program requirement. The importance of this topic of boundaries and how they relate to professionals cannot be stressed enough especially as it relates to rural communities.
Methods

Research Design

The purpose of the study was to explore hospice social worker’s perspectives of boundary issues as they relate to hospice in the rural communities. Since very little research has been conducted in relation to this topic, this study was exploratory in nature. In efforts to construct a methodologically sound study that would explore relationships between rural hospice social workers and clients who receive hospice care, the following was addressed: sample, protection of human subjects, recruitment process, data collection, data analysis, and potential strengths/limitations of the study.

Sample

The researcher searched and recruited eight participants \( (n = 8) \) for this study. The number of respondents was chosen based on the appropriate number suggested for this type of in-depth interviewing (Padgett, 2008). A convenience sample was utilized due to the researcher wanting to examine specific characteristics and area of practice in the participants. The sample was chosen in order to provide rich qualitative data for this research.

In order to be eligible for this study, eight participants meet the following inclusion criteria including their professional experience, licensure, and work location. The participants had at least one year of direct experience working within the hospice field. Second, they were a licensed social worker. Third, the participants practiced in at least one rural county that had a population core with no more than 50,000 people. Please note this study adheres to the “rural” definition as designated by the Office of
Management and Budget’s (OMB). These are counties considered Micropolitan which have a population core of at least 10,000 people but no more than 50,000 people or are “neither” which both Micropolitan counties are considered rural.

Demographic information.

No personal demographic information was collected from the eight women (n = 8) who were interviewed as part of this study. While not asked directly, all eight women appeared to be white (non-hispanic).

Work experience.

While the rural hospice social workers were ethnically the same, greater range was present with regards to participants’ overall years of work experience. Participants’ overall years of work experience ranged from 1.5 years to 28 years. Three participants currently had between one to 10 years of experience in hospice, three participants reported 11 to 20 years of experience, and two participants described 21 to 30 years of experience as social workers in the hospice field. On average, participants had worked in rural hospice settings approximately 15 years.

In addition to being asked about their years of experience working in hospice, participants described what they did for their jobs. The majority of participants (n = 5) had two roles within the hospice agency, most commonly as social worker and bereavement coordinator. Two social workers described that their primary role within the hospice setting as either social worker or bereavement coordinator. One social worker reported fulfilling three roles as social worker, bereavement coordinator, and volunteer coordinator. Three social workers also described having other job roles outside of hospice
which included: home health and hospital social work position. The description of years of experience and job roles can be seen in Table (2).

Table 2

<table>
<thead>
<tr>
<th>Years of experience</th>
<th>n=8(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-10 years</td>
<td>3 (37.5%)</td>
</tr>
<tr>
<td>11-20 years</td>
<td>3 (37.5%)</td>
</tr>
<tr>
<td>21-30 years</td>
<td>2 (25%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Roles in hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social work                                                1 (12.5%)</td>
</tr>
<tr>
<td>Bereavement                                                1 (12.5%)</td>
</tr>
<tr>
<td>Social work/bereavement                                    5 (62.5%)</td>
</tr>
<tr>
<td>Social work/bereavement/volunteer                          1 (12.5%)</td>
</tr>
<tr>
<td>Other job roles outside of hospice                         3 (37.5%)</td>
</tr>
</tbody>
</table>

Note: This information reflects participants’ discussion of job roles.

Recruitment

The type of recruitment used for the study was convenience sampling. The researcher contacted hospice agencies prior to interviewing to receive permission to contact the social workers within those agencies this prior consent can be seen in Appendix A. The agencies chosen for prior permission with agencies that were located within a rural community designated rural by the OMB definition of rural. A letter of introduction was given to hospice directors which can be viewed in Appendix B. After receiving written permission from directors of the hospice agencies, the potential participants were either called or e-mailed depending on the type of contact suggested by the hospice directors. Six of the participants received a phone call after prior permission from the agencies and a phone script was utilized which is in Appendix C. One of the participants was e-mailed an e-mail script which can be viewed in Appendix B. The e-
mail also included a recruitment flyer which is in Appendix D. One of the participants was recruited through another participant suggesting the potential participant would be interested in being interviewed for the study. None of the contacted potential participants declined to participate. The participants received a ten dollar gift card for contributing to this research.

**Protection of Human Subjects**

Due to the nature of the study, confidentiality is of the utmost importance. In order to protect confidentiality, participants were given the informed consent form which is in Appendix A before beginning the interview which included, background information, procedures, risks and benefits of being in the study, compensation, confidentiality, voluntary nature of the study, and signature of consent; this can be viewed in Appendix F. The researcher also explained the purpose of the study, process of the research, and asked for questions. The researcher verbally addressed the participant’s rights, the voluntary nature of the study, and issues of confidentiality. In order to confirm the participant understood the information being provided, the researcher asked open-ended questions.

Overall, risk for this study is minimal. The semi-structured questionnaire was open-ended in nature, and reflected knowledge of rural hospice work that is commiserated with theoretical/conceptual literature as well as empirical studies in this topic area. This researcher’s 682 clinical paper committee, as well as, the University of St. Thomas IRB reviewed the content of semi-structured interview questions prior to conducting the interviews.
Care was taken to reduce the overall risk for participation in the study in the following ways. First, licensed providers rather than hospice patients or family members were recruited to participate in this study. Second, the voluntary nature of the study was emphasized to those who met inclusion criteria for the study: the right to skip over questions or to end the interview was noted concerning the written informed consent and the verbal review of the informed consent with the researcher prior to the interview. Third, to address any concern regarding the potential for discomfort experienced by those who participated in the interviews, a resource sheet was given to offer professional and personal resources.

In this study, several precautions were taken in order to safeguard confidentiality of participants. Participants were told that their inclusion in this study is voluntary and they are allowed to stop at any time. Participants were told that they could skip any questions that they did not feel comfortable answering. The participants also were given the informed consent form which was explained to them verbally. The researcher asked open-ended questions in order to establish if the respondent understood the informed consent such as: *Please explain your understanding of your role in this research? How do you opt out of being part of the research? And what is the study about?* A resource list was given to each participant and can be referenced in Appendix E.

In continuance of confidentiality, once the data was collected it was de-identified so interviews cannot be linked with particular respondents. The information was stored on a personal computer that is password protected. The digital audio-taped interviews were stored on the password protected computer which was stored in a locked and secure location. Transcripts were also stored there so the validity of the data can be maintained.
The paper transcripts will be destroyed on July 31st, 2014. The research was approved by an institutional review board through University of St. Thomas/St. Catherine University in order to ensure confidentiality was met and participants were protected.

**Data Collection**

The data was collected using a semi-structured interview process which allowed the use of open-ended questions and attempted to understand the participant’s perspective (Barker, 1999). The semi-structured interview process was chosen to allow a natural flow to the conversation and for the participants to fully engage in a conversational way. The interviews lasted between 17 minutes to 65 minutes with an average of 40 minutes.

The place of the interview was also taken into consideration. The location of the interview was private location which allowed for the participant to be comfortable sharing during the interview. The participant chose the place of the interview which typically was the participant’s office or another private location within the hospice agency. After the informed consent process happened, the interviewer allowed for a time of questions and clarification as needed. The interview was digitally audio-recorded with the permission of the participant.

The interview questions were influenced by the literature review as they related to professional boundaries, end-of-life care, and rural community practice. The questions addressed a number of issues such as boundaries as it related to hospice and rural community, dual relationships, and management of boundaries within this scope. The questions focused on defining professional boundaries, micro-, mezzo-, and macro-practice questions and can be viewed in Appendix F. The defining questions allowed the participant to define professional boundaries as they see fit and to discuss the importance
or non-importance of boundaries. Micro-questions focused on professional boundaries as related to clients and co-workers with an emphasis on maintaining boundaries. Mezzo-questions focused on boundaries between home and work life and how agency practices influence professional boundaries. Macro-questions focused on professional boundaries within the rural community; these questions integrated dual relationships management of the professional in the rural community context.

**Data Analysis**

The data collected as part of this study was analyzed via the “grounded theory” method. *Grounded theory* methodology allows for uncovering of a theory through looking at the data at hand. The data was the first information examined and was to be as close to the original data as possible before theories can be constructed. It allowed the researcher to have theories or concepts but did not allow these to drive the research (Padgett, 2008).

Each line was given a code and as multiple codes emerge themes were identified. There will be three rounds of data reduction conducted. The transcripts which were transcribed by the researcher were first reviewed line by line and assigned “codes” which “involves close and repeated readings of the transcript in search of ‘meaning units’ that are descriptively labeled so that they may serve as building blocks for broader conceptualization” (Padgett, 2008 p.152). Then a list of codes was written up for each transcript. As common codes were recognized, a master list of codes emerged. These codes are systematic and search for comparisons and contrasts between the interviews (Padgett, 2008). As similarities of comparisons and contrasts happened in coding, the presence of “themes” and “sub-themes” presented themselves. These were simply links
between codes that have been developed. These themes attempted to encompass all the
data collected as best possible.
Findings

This section presents the findings from interviews with rural hospice social workers \((n = 8)\), which resulted in the development of three distinct themes. The three primary themes that emerged over the course of these interviews included: (1) the rural community and the grocery store experience; (2) the methods of maintaining professional boundaries; and finally, (3) the professional boundaries that are present within hospice settings. Within these three main themes, additional subthemes were to be found. Under the theme of the rural community and the grocery store experience, three subthemes were identified: confidentiality, the rural professional, and dual relationships. Within the second theme of methods of maintaining professional boundaries, the two subthemes were as follows: ways an agency can help professional boundaries and self-care methods for professionals. The final theme—professional boundaries within the hospice setting—contained two subthemes: professional boundaries with patients and professional boundaries with co-workers. The themes can be seen in Table 3.
Table 3

**Themes/Subthemes and Sample Responses Among Rural Hospice Social Workers**

<table>
<thead>
<tr>
<th>Category</th>
<th>Thematic category</th>
<th>Sample response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1: Rural community and the grocery store experience</strong></td>
<td>Confidentiality</td>
<td>I think everybody does a very good job of maintaining confidentiality that can be more of a challenge I think for those folks in smaller community because you know everybody knows everybody and word travels so fast.</td>
</tr>
<tr>
<td></td>
<td>The professional</td>
<td>You just be a responsible person in public.</td>
</tr>
<tr>
<td></td>
<td>Dual relationships</td>
<td>A patient that went to my church you know I knew them before hand and so you do have a connection because you had that relationship before so it’s a fine line to tread.</td>
</tr>
<tr>
<td><strong>Theme 2: Maintaining professional boundaries</strong></td>
<td>Boundaries with patients</td>
<td>Some people would say you can’t get attached or you can’t get close to someone. I don’t know how that is humanly possible. You can’t serve if you don’t connect.</td>
</tr>
<tr>
<td></td>
<td>Boundaries with co-workers</td>
<td>You don’t yell at each other you’re respectful but there’s also that boundary of knowing your co-worker and how much that person can handle.</td>
</tr>
<tr>
<td><strong>Theme 3: Methods to helping professional boundaries</strong></td>
<td>Agency</td>
<td>I’d say one of the biggest one is just lead by example you know if our supervisors aren’t selling that professionalism we as employees think it’s okay not to do as well.</td>
</tr>
<tr>
<td></td>
<td>Self-care</td>
<td>I want to protect the time when I am away from…not at my work.</td>
</tr>
</tbody>
</table>

*Note: C = community (rural): three subthemes; B = boundaries two subthemes; H = helping professional boundaries: two subthemes.*

**Description of Agency Settings and Work Roles**

For this study, respondents were asked what category of agency they currently worked in and their years of experience related questions along with what their job roles were within and outside of their hospice settings. Demographic questions were asked.
pertaining to the type of agency and agency settings where respondents worked. The participants in the study came from a variety of agencies such as hospital-based \((n = 4)\), standalone non-profit \((n = 2)\), and stand alone for profit \((n = 2)\) agencies.

The type of community that participants currently lived in was also reported. The majority \((n = 7)\) reported living and working in a rural community. Only one participant reported living in an urban community and working in rural areas. The participants who lived in rural communities reported experiencing some form of dual/multiple relationships while only one participant reported experiencing no dual/multiple relationships. The current community and experience of dual relationship can be seen in Table 4.

<table>
<thead>
<tr>
<th>Description of Participants’ Community and Dual/Multiple Relationships</th>
<th>n = 8 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of community lived in</td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>7(87.5%)</td>
</tr>
<tr>
<td>Urban</td>
<td>1(12.5%)</td>
</tr>
<tr>
<td>Experienced a dual/multiple relationship</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7(87.5%)</td>
</tr>
<tr>
<td>No</td>
<td>1(12.5%)</td>
</tr>
</tbody>
</table>

Note: This information reflects participants discussion of current living status and dual/multiple relationships.

The Rural Community and the Grocery Store Experience

Confidentiality.

Over the course of their interviews, participants discussed the nature of confidentiality in rural communities in a variety of ways. All of the participants \((n = 8)\) in the study agreed that when a professional is in a rural community there can be more opportunities to breach client confidentiality. This was talked about in terms of how everybody knows everybody and how a professional must maintain confidentiality in those circumstances.
In addition to the challenges of maintaining confidentiality within rural settings, all respondents also discussed the ways in which confidentiality can be challenging to maintain within small communities. Engrid discussed this in efforts to address this challenge, her team works hard to maintain confidentiality, “I think that everybody does a good job maintaining confidentiality that can be more of a challenge I think for those folks in a smaller community because you know everybody knows everybody and word travels so fast.”

Another prevalent theme inherent to maintaining confidentiality while working in the rural community was that “everybody knows everybody.” Seven out of the eight participants discussed this “everybody knows everybody” in a small community. Of those participants that described this, they reported in relation to going to the grocery store or to another public place. While going to these public places, six out of eight of the participants described being approached by community members wondering about clients on the hospice program. Carrie discussed this situation at the grocery store, “If someone comes and asks us, ‘How is so and so doing on hospice?’ or ‘I just saw so and so at the hospice house how are they doing?’” While Ann and Francis described the same phenomenon the community members often approached them asking about the well-being of current hospice clients.

Along with being asked about hospice clients, the participants also discussed the manner in which they addressed this issue of confidentiality. Six out of eight participants elaborated on their method of answering community members’ inquiries regarding current clients who were in hospice. Overall, participants (n = 8) agreed that they do not divulge any information about hospice clients or whether a certain client is on hospice.
To illustrate this point, Bonnie shared her standard answer when asked about confidential information concerning hospice patients, “Well I’m sorry but I can’t share anything with you.” Dawn gave an example of how she would redirect conversation by saying, “I think you should talk to the family about that.” Similarly, Francis reported what she did when confronted about confidential information, “We cannot discuss who we are or not seeing in the home and we are not at liberty to discuss that.” Although it can be challenging to manage these inquiries about confidential information, Dawn and Francis reported having empathy towards community members who do ask about clients and families as they felt it came from a place of genuine care and concern for those clients and families.

**The Professional.**

In addition to encountering challenges that pertain to confidentiality within rural communities, respondents also spoke to the challenges and burdens of being viewed as a professional within the larger community even while not engaged at work. Six out of eight of the participants shared their thoughts about being recognized as a professional in the rural community. These statements included information about community members knowing the professional and the professional’s role in hospice. Ann described the dilemma of community members recognizing participants as hospice professionals, “It’s you know running into people when you’re at church or at the grocery store just maintaining that friendship when it needs to be a friendship and the professionalism when it needs to professionalism.” Holly explained how community members knowing a participant’s professional role can be difficult for a professional if they are out in the community and for example trying to parent their child. “You just want your kids to
behave.” Holly went on to discuss that she feels her parenting skills in public may impact how community members view her skills as a social worker.

In addition to community members knowledge of participants’ professional work roles, respondents also described what it was like for these community members to know personal information about them, as well. Participants \((n = 6)\) reported their feelings in regards to community members knowing about their personal lives and/or had information about their family members, the cars they drove, and where they lived. One respondent, Dawn, spoke to how community members both knew what car she drove and place of residence. This personal knowledge has the power to impact a professional’s reputation (e.g., a previous professional partied in the community and how that had serious consequences on the professional’s career).

Even though community members have much knowledge about the professional, the participants found ways to cope with this threat to their privacy. For example, Carrie shared one strategy she employed when going out in public,

\[
\text{I choose when to go to the grocery store. I go to the smallest one and I like that best and I go I try to go when it isn’t high... the busy time because I could be in there a long time by past family members.}
\]

She went on to describe, “You have a lot of people coming up to you and maybe just touching, sharing a thought, or a concern or whatever I think you got to protect yourself from that.” She also went on to share how she facilitates a group for bereaved family members as a way for the past family members to stay connected with her in an appropriate professional relationship.

Dawn also found ways to cope with the breach in privacy by sharing examples of how other professionals have coped. She reports that a friend of hers has a system with a
local bartender to give her a special type of drink when certain community members are present. Another respondent, Ginny, explained a different method of protecting herself, and reported if she participated in community events; it will only be family-orientated in nature. She said that she retained a social life in an area quite a distance away to maintain privacy with her personal life.

Even though participants found ways to cope with their private lives being the subject of public evaluation in the rural communities where they lived, other participants described the difficulty of incidental contact with past clients and families in public. Four participants conversed about whether to acknowledge or not to acknowledge their professional relationship with the client or family members. Holly and Carrie both agreed, they acknowledged past family when they see them out in the community. Carrie stated, “I certainly acknowledge them and ask how they are doing depends upon where they are at on their grief journey.” Both stated that understanding the client or family is essential on whether to acknowledge or not. Ann and Bonnie stated that they never acknowledge past family members unless those members acknowledge them first. Ann stated, “Unless they approach me or acknowledge me I don’t acknowledge them it’s just a simple guideline to follow.”

**Dual relationships.**

When being a professional in a rural community, participants reported encountering multiple/dual relationships with clients and family members. When asked about experiencing dual/multiple relationships, seven out of eight of the participants had encountered this at some point in their career. The multiple/dual relationships ranged from close relatives on hospice to taking care of well-known business members of the
community. The dual relationships included being the social worker to these people and also being the family member of a person on hospice that is cared for by the hospice company. One respondent, Dawn, spoke to the inevitable nature of encountering dual/multiple relationships as a hospice social worker in a rural community, “When you live in a small town, I just don’t know how you don’t have those.”

Within multiple/dual relationships participants discussed the challenges of navigating these types of relationships. Of the seven participants that experienced dual/multiple relationships, six described challenges that came with these relationships. Other participants (n = 3) described the challenges of maintaining objectivity with these types of relationships. Francis illustrated this as she discussed this loss of objectivity in dual/multiple relationships as she became the social worker for a close relative, “I think you can lose objectivity because you just do that it’s a normal thing. You forget how to be a social worker when it’s your family member; you forget how to be a nurse. It’s very normal.” She also related how common it is in dual/multiple relationships for a person reverts back to the role that they play in that family versus their professional role.

Participants reported maintaining objectivity can be a challenge in dual/multiple relationship but also confidentiality and professionalism can be a challenge to maintain as well. Another respondent, Bonnie, talked about the challenges with confidentiality when counseling the patient and the patient’s family member is a friend. Dawn and Ann both stated that maintaining professionalism in conversation with dual/multiple relationships can also be an obstacle to remaining professional in the relationship. Two of the participants related how when a professional has a family member on hospice, a professional can have unrealistic expectations of the hospice staff. As Holly states, “I
(had) higher expectations because I knew what a good death should look like and I knew what hospice could provide.” Ginny also described a similar occurrence when staff have their family members on hospice.

When navigating dual/multiple relationships, two participants were distressed with what might happen. Ginny and Francis both struggled with the “what ifs” when being in a dual/multiple relationships. Francis reflected on the dual relationship she experienced wondering about what could have happened and stated, “So it turned out fine in the end she’s (the dual relationship relative) coping well but what if she had issues she would have talked to someone else about but not me because I was a related you know.” Another respondent, Ginny, reported that she was also relieved that the dual relationship she experienced worked out well. She reported that she wondered if her reputation in the community would have suffered if the relationship had ended poorly.

Along with struggles with dual/multiple relationships, three of the participants discussed the absence of other available social workers to resume responsibility for clients in the case of multiple/dual relationship clients. Dawn reflected on how reassigning clients to other qualified hospice workers in rural areas was simply not an option due to lack other staffing options, “It’s just when you are so small town like this it’s many agencies only have one social worker.” She went on to discuss how this flows over to finding mental health resources for patients as there may be only one mental health practitioner in the area. Bonnie also reported that the agency she works for, allows her to say “no” to dual/multiple relationships, “They always do give you the options to say ‘no’ but you know it’s really impossible to find someone to cover you so you don’t feel like you can physically take that option.” The challenge of finding a hospice social
worker to take a patient may require the covering social worker to drive long distances to see only one patient as both Bonnie and Francis discuss.

Even though many challenges were discussed, not all the information on dual/multiple relationships was pertaining to challenges of these relationships. Five participants related these relationships had positive aspects to them along with the challenges. Three participants relayed the dual/multiple relationships gave them better insight into the patient and their connection to the family also allowed them to build rapport quickly. As Ann said, “It can benefit you in the fact that they know you and trust you...you don’t have to build that initial rapport with them so that can help you kind of give you an ‘in’ with the family right away.” She went on to describe how this can be a positive component when a patient’s death does not allow enough time for rapport building. Carrie also reported positive aspect to dual/multiple relationships with patients and families, “I think they’re more open I think it’s a deep it’s a deeper kind of love or compassion.” While Dawn felt it gave her more intimate knowledge about that family. “There was trouble with a family member because I mean so it was to help you know maybe mend some of those fences while they had the opportunity.” Holly’s experience with a family member on hospice gave her more appreciation of different job roles within the hospice team.

I think I realized even more so what a hard job it is especially sometimes for the nurses like what a helpless feeling that is for families are looking at you and having this expectation that you need to fix it. Holly’s experience also brought policy changes that allowed nurses to control pain more effectively for home hospice clients. Overall, these participants articulated that they felt these relationships had benefits along with challenges.
Maintaining Professional Boundaries

Professional boundaries with hospice patients.

The participants not only reflected on the rural community but general professional boundaries as well especially with hospice clients. While all eight participants agreed professional boundaries were important in the hospice setting, there was a lack of consensus regarding what these professional boundaries should look like. Six out of eight of the participants agreed that the relationship with hospice can become very emotional and create attachments. Ginny talked about her tendency to develop an emotional connection with hospice clients as death creates a unique situation for social work,

*You do care for people and you get attached...death is a little bit different than any other area of social work. You’re learning their deepest, darkest fears and you’re getting them ready for the biggest moment of in their life so it can be very, very hard to maintain a boundary.*

Given this emotion, one thing that differed between social workers is the amount of emotion that is shown with these connections. Bonnie talked about how she rarely cries in front of patients and families because,

*In order to help a patient and his or her family you have to have a boundaries there because if you are too emotionally involved it’s difficult to help that patient or family. You know you need to step aside and show that you are strong for them so that if they are grieving they can feel comfortable grieving in front of me.*

While Francis states that she is more willing to show emotion in front of patients and families, “I’ve decided that then they realize whatever they’ve said was meaningful to me too.” Even though participants did not agree on how much emotion to show, the majority of the participants talked about how it’s a constant process to monitor their level of emotional involvement but yet these emotions are still an important part of the
relationship. Carrie and Francis discussed how connections to clients and families were still important. Francis said:

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I’m not there to be like their buddy, however when I started it was always emphasized that you need to sort of keep your distance, don’t get too emotionally involved…well just to say that’s a crock because people are dying.
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Carrie emphasized that the importance of the strength of the professional relationship, “If you can’t connect, you can’t serve.” Engrid also stressed the importance of these boundaries for the professional, “There are boundaries that we have as professional social workers not to over step those boundaries so you need to protect your integrity, your reputation, your license.” Five out of eight participants agreed that boundaries protected the professional from things such as burnout and ethical violations.

Given the emotional connections that happen in hospice, participants described a variety of ways that professionals breach or violate professional boundaries. Half of the participants who were interviewed for the study (\(n = 4\)) described acts that were done above what the role of the professional called for such as visiting patients on days off, giving out personal phone numbers, bringing a meal in for a family, and overall helping too much. Ginny discussed how she decides if what she is doing is appropriate for a client or family, “If you aren’t going to do it for all you can’t do it for one.” The number one act that was mentioned by participants was giving out personal phone numbers as a breach of professional boundaries. Three of the participants discussed how experience plays into the breach of professional boundaries. Engrid explored how her experience has shaped her own professional boundaries, “I think that comes with experience you that time you do your job and you see things and you know ‘I can’t go there.’ So you learn as
you go.” The other two agreed that their years of experience have taught them how to better maintain professional boundaries with clients and families.

**Professional boundaries with co-workers.**

While participants expressed that professional boundaries with clients and families were important, they also discussed boundaries with co-workers. Ideas of professional boundaries with co-workers varied from participant to participant. Overall, five participants reported that maintaining a difference between work life and home life was important for co-workers and for themselves. Ann indicated that she considers this important for herself especially, “I’m not going to come to work and bring whatever happening at home into work because that affects my co-worker’s life.” Meanwhile, Holly discussed how showing favoritism to certain employees such as scheduling favorable shifts and discussing personal relationships at work as breaches of boundaries with co-workers. Also, three participants described being respectful of one another as a person and also of their time was important. They also cited that it was not appropriate for co-workers to lash out at one another or back talk about each other as it can impact team work.

In addition describing their professional boundaries with co-workers, four participants explored judgmental statements that other co-workers stated regarding clients and families. The participants agreed that judgmental statements against patients showed that co-workers needed to deal with feelings related to those patients. These participants felt that they needed to address these statements with the co-worker that was stating them. Carrie reported that her method of coping with judgmental statements involved discussing it with that person in a non-confrontational way, “We can ask questions that
help them see what they already know in their soul but bring it forward it’s just that much more meaningful for the person and much more healing.” Three participants elaborated that they often take on the role of counselor with co-workers also as Francis stated, “As a social worker the way I was trained you are to be there for your co-workers and so I see that as part of my role.” The participants agreed that it was important to understand your co-workers in order to provide proper counseling for their needs.

Methods to Maintaining Professional Boundaries

Agency.

All participants agree that maintaining professional boundaries is important and also that agency can help support professional boundaries. All participants agreed that an agency can either help and/or hinder professional boundaries and stressed the importance of teamwork/team approach within the hospice setting and how that can encourage professional boundaries. Francis explained why this team approach for hospice which is designated by Medicare was so important:

One thing that Medicare does will is that they expect a team approach you know it’s to be a nurse, social worker, spiritual, volunteer coordinator, aides, volunteers, and the whole ball of wax because a person is not just this physical being.

The participants went on to explain how Interdisciplinary Team Meetings (IDT) were beneficial for the team to understand one another and to maintain those boundaries. Francis expressed the importance of these team meetings, “IDT is a really good place where we can meet and discuss clients.”

Along with Interdisciplinary team meetings, four participants put a strong emphasis on the type of leadership they received. Ann reflected on professionalism and supervision, “I’d say one of the biggest one(s) is just lead by example you know if our
supervisors aren’t selling that professionalism, we are employees think it’s okay not to do as well.” Another respondent, Carrie, reported that if leadership places a strong emphasis to do beyond the professional role, employees feel obligated to do the same which can be both beneficial and harmful to employees.

Along with teamwork and supervision, four participants reported that their agency has or is engaging in a debriefing process for their employees. The debriefing process allowed time for employees to process feelings related to a patient’s death either immediately following or a designated time such as a monthly staff meeting. This debriefing process may function differently for each agency but overall the participants reported it helpful for maintaining professional boundaries. Bonnie described their debriefing process that occurred after a patient passes away,

Well… we sit down as a team and just talk about “How are you doing?” you know “What are you thinking right now?” “What kinds of things may help you through this?” “Do you feel like you’re doing okay?” “Do you feel like” you know we just kind of talk about (how) we’re doing.

Francis and Ginny felt this allowed hospice employees to properly grieve the loss of patients. Although all \( n = 4 \) agreed that the debriefing process is helpful, Ginny voiced that this process can be difficult as hospice professionals worry about what co-workers may think if they share their feelings. Francis reported that this process can be difficult to start and maintain due to budget concerns and time management.

Teamwork, leadership, and debriefing process remained the largest themes through ways an agency manages professional boundaries, but some smaller themes were noted. Three participants related that some form of being “on-call” can be a challenge to professional boundaries as it can blur the lines between work and home life. Two participants agreed more education was important to maintain professional boundaries.
since it is something that is not discussed on a daily basis. Good communication between staff members was also recognized by two participants as also being an important measure against professional boundary breaches and violations.

**Self-care methods.**

In order to maintain professional boundaries while working in hospice within rural areas, participants recognized the importance of addressing and maintaining self-care. During the interview process, seven of the eight participants reported that they do some form of self-care to help with professional boundaries. Carrie described this connection between self-care and being a good social worker,

*I think you are able to connect more on soul level with people so it empowers rather than drags me down. But I also like to take care of myself by doing things that are interesting to me and making a point to do that.*

Among participants, each varied in what forms of self-care they believed in or participated in for themselves. Carrie reported that she advocated the use of vacation time, traveling, meditation, physical exercise, positive people, socializing, cooking, reading, healthy distractions from work, sense of humor, and embracing dying as ways to help her care for herself. Dawn utilized reading, grandchildren, Facebook, babysitting, and exercise. Bonnie enjoyed working part-time, made use of her time off, and relied on her husband for support. Overall socializing with family and friends, use of vacation time, reading, and physical exercise remained the highest used methods of self-care.

Even though seven of the participants reported self-care methods, three reported a distinct method of transitioning from work to home life. Ann reported that she likes to work-out right after work or “I usually make sure I’m doing errands around town until my mind shuts off, it’s just a matter of keeping busy.” Dawn said that she previously
visited family in the nursing home right after work, but is now attempting to adjust her
method of transitioning after the family members passed away. Francis uses her 20 to 25
minute drive to replay the day and after a while begins to give her mind tasks that need to
be accomplished at home and once home played a game of Mah Jong to complete her
transition from work to home life.

**Summary**

Participants in this study expressed a wide range of beliefs relating to professional
boundaries. Overall they agreed that professional boundaries were different in a rural
community especially as it relates to being a professional and maintaining confidentiality.
The majority of the participants had experienced dual relationships that had both positive
and negative aspects. They also relayed that hospice is a very emotional connection, but
disagreed on how to maintain that emotional connection. Participants were able to find
ways to cope with the emotion related to hospice through teamwork, supervision, and a
debriefing process. They also discussed a variety of self-care methods through
socializing, exercising, and time away from work.
Discussion

This research focused on rural hospice social workers’ professional boundaries through the lens of micro-, mezzo-, and macro- with professional boundaries seen upon a continuum between rigid and enmeshed boundaries. Although much of the research aligns with previous research, there were times when this research deviated from the previous research. This section will focus on both the similarities and differences between this research and previous research. The themes will be focused from the literature review.

Although very little research has been performed in the area of rural hospice social work and professional boundaries, two different lenses were utilized in order to understand this topic. The first lens is the Ecological Systems Theory of Bonfenbrenner (1993) which allows professional boundaries to be seen from a micro-, mezzo-, exo-, and macro- viewpoint. Participants in this study utilized these lenses in order to understand professional boundaries through the systems. Participants recognized how they interacted with clients on a micro- level was impacted by personal ideology, their past boundary issues, family concerns, agency policy, and the rural community. Each of these systems impressed the professional’s view of professional boundaries. The second lens was the Professional Boundaries Continuum as discussed by Davidson (2004) which boundaries are viewed on a line balancing between rigid and enmeshed. Participants had mixed feelings regarding professional boundaries especially dual relationships as some felt that boundaries should be rigid and others more enmeshed. Yet some participants reported this type of movement of boundaries between the two as the continuum suggests.

Through these two lenses the following themes were developed: the rural community
impact (grocery store experience), professional boundaries with clients, families, and co-workers, and maintaining professional boundaries.

Understanding the participants and the viewpoint of professional boundaries is essential when comprehending this research. The participants varied in their view of how professional boundaries should be conducted. Interestingly, only females were recruited for this study so much of the viewpoint of the participants’ was from the context of a female social construct. This aligns with the fact that there are more female social workers than there are male social workers. Along with this concept, much of the research on professional boundaries shows that females tend to have a more rigid set of boundaries than do males (Boys & Pope, 1989; Kitson & Spellinger, 2007; Ringstad, 2008). The participants who were recruited for this study also voiced a strong interest in professional boundaries within the rural community.

**Rural community and the grocery store experience**

In the first theme of the professional in the rural community the literature was rich in information concerning the uniqueness of the rural community. Overall the results were congruent with the previous research. Much of the research reports that “everybody knows everybody” in rural communities and this was echoed by the participants in the study (Haxton & Boelk, 2010; Helbok et al., 2006; Nickel, 2004; Pugh, 2006). The issue of confidentiality in a rural community was addressed minimally in past research but participants put a strong emphasis on this topic (Haxton & Boelk, 2010; Helbok et al., 2006; Nickel, 2004; Pugh, 2006). Another issue facing rural professionals is the lack of anonymity within the community which was a concern discussed in past research and also by the findings of this study (Haxton & Boelk, 2010; Helbok et al., 2006; Nickel,
Dual/Multiple relationships were explored in previous research and were an aspect that the findings of the study touched upon (Haxton & Boelk, 2010; Helbok et al., 2006). The previous research focused on the ethical aspects of dual relationships whereas participants focused on ways to cope with dual relationships (Borys & Pope, 1989; Haxton & Boelk, 2010; Kitson & Sperlinger, 2007; Ringstad, 2008).

With the participants in this study, the importance and challenge of maintaining confidentiality was stressed while in previous research the area of confidentiality was minimally reported. All the participants voiced there were many opportunities to breach confidentiality regarding hospice patients within the rural community. Previous research with psychologists, social workers, and therapists resulted in confidentiality as more of a challenge for rural practitioners than urban practitioners, which is also articulated by the participants in this study (Helbok et al., 2006; Nickel, 2004; Pugh, 2006). Although in a study by Haxton and Boelk (2010), which focused on rural hospice social work, reported that professionals felt that maintaining confidentiality was only a somewhat or little challenge which is in contrast to how the participants in this study felt about maintaining confidentiality. This contrast may be due to the wording of the questions asked by each study. In the study by Haxton and Boelk (2010), the challenge of confidentiality was contrasted to other areas of rural hospice social work such as lack of resources whereas participants for this study were asked about perceived challenges of rural hospice social work.

Along with confidentiality, the lack of anonymity was similar between this research and previous literature. In a study by Helbok et al. (2006) and the study by Haxton and Boelk (2010) of rural and urban professionals, rural professionals reported
clients knowing personal information concerning the professional than did the urban professionals which is similar to the reports from the rural participants in this study. Participants reported community members often know personal information about the professional such as relatives, the vehicle the professional drives, and where the professional lives (Curtin & Hargrove, 2010; Haxton & Boelk, 2010; Helbok et al., 2006; Pugh, 2006). This intricate personal knowledge about the professionals, as participants voiced often led to feeling like professionals 24 hours a day which is a challenge also cited by previous research (Cohn & Hastings, 2013; Curtin & Hargrove, 2010; Haxton & Boelk, 2010; Pugh, 2006). This lack of anonymity for hospice professionals may lead to increased burnout and isolation as a professional feels that they never get a break from their work. Even though many findings were supported by the previous research, in the study by Haxton and Boelk (2010) and other research discuss the prevalence of “feeling isolated” by rural professionals due to avoiding always feeling like a professional, whereas, in this research only one participant reported feeling isolated but found ways to cope with this (Cohn & Hastings, 2013; Helbrok et al., 2006).

Lack of anonymity was a prevalent topic in previous research, but very little research was present in regards to guidelines as a professional to follow in a rural community (Cohn & Hastings, 2013; Helbrok et al., 2006). Although no articles discussed guidelines qualitatively, the article by Cohn and Hasting (2013) offered suggestions for rural practitioners such as engaging positive community involvement through volunteering and attending church. In addition, the participants in the study offered a range of ways to cope with this visibility by having a key phrase that they say to community members when community members ask about hospice patients. Many
participants were able to effectively redirect conversations to more appropriate topics and used humor to make the community members feel more comfortable when participants were unable to share information. Participants also avoided certain establishments such as bars and choose to attend only family-orientated activities. They offered suggestions such as pouring alcohol out of a bottle into a glass to avoid judgments that may impact the professional’s reputation.

Dual/multiple relationships were a topic of debate within previous research, and participants reported experiencing many of these relationships. Participants who lived in the rural community and practiced in the rural community reported more dual/multiple relationships than did the urban participant who worked in the rural community which similar to findings of several other key studies (Gillespie & Redivo, 2012; Halverson & Brownlee, 2010; Helbok et al., 2006). The participants struggled with the ethics of dual relationships, and this struggle is also found previous research (Haxton & Boelk, 2010; Helbok et al., 2006; Nickel, 2004; Pugh, 2006). The literature supports that dual/multiple relationships are one of the main reasons social workers were sanctioned for so concerns are founded (Strom-Gottfried, 1999). Participants and previous research concur that loss of objectivity by the professional was a top concern when engaging in dual/multiple relationships (Ringstad, 2008; Strom-Gottfried 1999). One area that literature was silent on was how dual/multiple relationships affect the professional’s reputation. Participants struggled with the question of “what if” when engaging in these types of relationships. Participants, who engaged in dual/multiple relationships, reported good outcomes from these relationships, but a few participants wondered what would have happened if the relationships went poorly.
Even though challenges are a part of dual/multiple relationships, the findings of this study support positive aspects to these relationships. The dual/multiple relationship can create an atmosphere of trust and easy rapport building in the client/professional relationship which has been discussed in previous research, and participants verbalized it was a positive aspect in the time-limited relationship between the hospice client and family and the social worker (Cohn & Hastings, 2013; Gillespie & Ridivo, 2012; Haxton & Boelk, 2010). The findings support that dual/multiple relationships can give them special insight and knowledge to the professional concerning the hospice client and family which was also addressed in previous research (Cohn & Hastings, 2013; Gillespie & Ridivo, 2012).

Due to the fact that previous research gives little guidance on how to effectively manage dual/multiple relationships, the participants in this study found ways to manage these relationships (Boys & Pope, 1989; Haxton & Boelk, 2010; Reamer, 2003; Ringstad, 2008;). The participants discussed the importance of addressing dual/multiple relationships in the beginning of the relationship which aligns with the findings of study by Helbok, Marinelli, and Wall (2006) that rural professionals are more likely to discuss dual/multiple relationships in the beginning of the therapy process. While other participants in this study felt it was important to address issues as they went along because of the uncertainty of how to proceed in these relationships. The findings suggest a need for self-awareness but participants often lacked the language to exemplify exactly what it means but felt they would know if they crossed a boundary. There did not seem to be a clear distinction on steps to follow when addressing dual/multiple relationships.
which was also discussed in much of literature (Boys & Pope, 1989; Haxton & Boelk, 2010; Reamer, 2003; Ringstad, 2008;)

The findings of this study suggest that professionals struggle with confidentiality, lack of anonymity, and dual relationships which are areas of concern in previous research. The participants in this study gave much depth to how to cope with these challenges in the rural community. Even though dual/multiple relationships with clients have many challenges, literature and findings suggest that the ability to build rapport quickly and establish trust can be helpful to the professional/client relationships especially to the time-sensitive nature of hospice (Cohn & Hastings, 2013; Gillespie & Ridivo, 2012; Haxton & Boelk, 2010). Still research lacked consensus on dual/multiple relationships and ways to manage these relationships which the findings suggest professionals felt unclear on how to manage dual/multiple relationships (Boys & Pope, 1989; Haxton & Boelk, 2010; Reamer, 2003; Ringstad, 2008).

**Professional Boundaries in Hospice**

The findings of this study and previous literature report hospice professionals face boundary challenges within the rural community, but it also suggests that boundary challenges happen within the professional-client relationship. As findings report, participants voiced that hospice can lead to a high emotion connection between clients and the hospice professional which aligns with the study by Sanders Bullock and Broussard (2012). The same study went on to report the unique situation of hospice professionals as clients are often in a very vulnerable state which findings of this study also suggest (Sanders et al., 2012). Participants stressed the importance of understanding their role as a professional and the use of power in the client/professional relationship.
Along with the unique role the hospice professional has, the findings of this study and previous research agree that boundary breaches happen when professionals go outside of their job scope. Participants reported if a person went outside of their scope as a professional this can lead to boundary breaches. In the study by Sanders, Bullock and Broussard (2012), it defines this type of breach in theme as “going above and beyond” which professionals do things for certain clients and families that they might not do for all patients. This theme was stated over and over again by participants in the form of professionals giving out personal cell phone numbers, buying gifts for clients, and bringing meals to clients. However, participants did not report any boundary violations by themselves or co-workers which is incongruent with previous research (Haxton & Boelk, 2010; Sanders et al., 2012). The lack of boundary violations may be due to participants wanting to protect themselves or other co-workers. In order to avoid “going above and beyond” the study by Sanders et al. (2012) and the findings of this study suggest asking, “Would I do this for all the patients?” in order to decide if a service is appropriate for a client.

This research reports that participants discussed professional boundaries with co-workers as well as with clients which the previous literature is relatively absent on. The literature on boundaries with co-workers is relatively absent except for the impact of supervision (Sanders et al., 2012). The participants discussed the importance of co-workers maintaining a balance between home life and work life in order to prevent boundary breaches. The literature briefly discusses how agencies can promote “going above and beyond,” as detrimental to professional boundaries, but it does not discuss the impact of co-workers poor boundaries on those around them (Sanders et al., 2012).
Participants reported these poor boundaries of co-workers can negatively impact how they interact with the clients they are serve.

Hospice professionals assist clients and families at a very vulnerable time in the life span which this study and the literature feel creates a very emotional connection in the client-professional relationship (Claxton-Oldfield et al., 2011; Sanders et al., 2012). This study and previous research suggests that boundary breaches happen when professionals go above their job role and this can be encouraged by agencies (Sanders et al., 2012). The previous research found boundary violations happen within hospice but the participants in this study reported none (Sanders et al., 2012). The findings of this study suggest boundary breaches happen between co-workers at work as well but research lacked insight into this phenomenon (Sanders et al., 2012).

**Maintaining Professional Boundaries**

Even though professional boundaries varied from participant to participant in this study, research and this study propose various ways of maintaining professional boundaries (Sanders et al., 2012). Findings of this study propose an agency with the good team work and leadership can help professionals which is also suggested by previous research (Sanders et al., 2012). The findings of this study convey a debriefing process may be helpful to hospice professionals in maintaining professional boundaries but previous research has not discussed this connection. Participants maintained professional boundaries with various forms of self-care methods and some of the participants also relayed rituals they engaged in to help maintain a balance between professional life and home life which was not discussed in depth in previous research (Reamer, 2003; Sanders et al., 2012).
With maintaining professional boundaries, this study and the literature agree that an agency can influence professional boundaries in teamwork, leadership, and supervision (Boys & Pope, 1989; Congress, 2001; Kitson & Sperlinger, 2007; Ringstad, 2008). In the study by Ringstad (2008), it discussed a professional working within an agency was less likely to commit a boundary violation while a participant also voiced the agency helped in maintaining their professional boundaries. In the study by Sanders et al. (2012), the study reported that participants stressed team work and interdisciplinary team approach as a means to decrease boundary violations which was also cited by all the participants in this study (Sanders et al., 2012).

Along with team work, the findings of this study also reported the importance of leadership within hospice. This study and the study by Sanders et al. (2012) concur that if team leaders set an atmosphere of “going above and beyond” the team members will more than likely follow this lead (Sanders et al., 2012). This study added depth to this phenomenon as participants reported leaders who make time for a debriefing process, general team meetings, and education can positively impact professional boundaries while leaders who focus on the bottom dollar, pushing team members to work more, too much on-call time, and look negatively on vacation time can be detrimental to boundaries. Along with leadership, good supervision was stressed in this study and the study by Ringstad’s (2008) also emphasized supervision as a means to help maintain professional boundaries (Boys & Pope, 1989; Kagle & Giebelhausen, 1994; Reamer, 2003). Participants added to the topic of supervision by voicing that caring supervision was important as hospice can be emotional at times.
Even though the leadership and supervision findings of this study were supported by previous research, the area of a debriefing process for hospice social work in the context of maintaining boundaries was not addressed by previous research. Participants in this study reported a debriefing process which is the process of discussing a death or struggles as a team is a helpful process to professional boundaries. It gives participants the ability to cope with multiple deaths and also watch for other hospice professionals who may be struggling with boundary challenges. This process may be even more helpful to rural hospice professionals as the boundary challenges not only exist in the hospice realm but also their interaction with the rural community.

Self-care was a influential focus of participants but the literature gave minimal consideration to self-care as it relates to professional boundaries (Davidson, 2005). Participants reported a variety of different ways to maintain a life outside of work including exercise, vacation time, traveling, and socializing. Even though much of the literature overlooked self-care methods and its implications to professional boundaries, literature did discuss the significance of it minimally (Cohn & Hastings, 2013; Davidson, 2005). In Cohn and Hasting’s theoretical article (2013), recommendations were made for healthy eating, exercise, and taking breaks for professionals to prevent burnout. While Davidson’s educational article (2005) gives the concept that self-care is an important aspect of maintaining professional boundaries and should be explored by professionals. Participants added to the importance of self-care by suggesting a professional develop a routine to transition from work to home to promote relaxation, including mindfulness techniques, meditation, focusing on positive aspects to hospice care, and utilizing healthy
people to promote professional boundaries, and understanding the self-care methods that work uniquely for that professional.

Maintaining professional boundaries in hospice was important to participants and also important within the literature (Claxton-Oldfield et al., 2012; Sanders et al., 2012). The findings of this study and previous research discussed the importance of team leadership and working in an interdisciplinary team. While previous research discussed supervision and team leadership, this study added depth to these methods. Participants regarded a debriefing process and self-care as significant in maintaining boundaries yet very little of the previous research focused on this connection between these influential aspects (Davidson, 2004). Finally, participants’ shared self-care methods that they felt were helpful to their process.

**Strengths and Limitations**

The qualitative study examined in-depth the nature of professional boundaries of rural hospice social workers’. The interview process allowed participants to give depth and understanding to this field of study. The knowledge gained by this study will enhance the research already present on the subject and will allow for more understanding of the rural hospice social work experience.

The qualitative nature of the study allowed for participants to fully engage in the research process. Given the open-ended nature of the questions, participants were able to add more information and the researcher was allowed to clarify and expound the information given by the participant. Additionally, the social workers, who participated in this study, came from a variety of agencies, and had differing numbers of years of experience in the hospice field. Also, as the researcher presented this topic, the
participants verbalized the importance of this topic especially as they practiced in the rural community.

Although the research has strengths, it also has limitations as well. The sample of the research is a convenience sample, which means that the results cannot be implicated for all rural hospice social work. Due to this type of sampling for the research, all the participants were female and therefore there is a gender inequality in participants. Even though the qualitative nature of this research allows for more in-depth conversation, it does not allow for a large number of participants so the research contained only eight participants.

The qualitative nature of the study is strength but may also impede the research process. All of the interviews were conducted face to face which does not allow for complete anonymity of the participants. The participants may have not answered all questions honestly due to the researcher conducting the interview. Similarly, the questions utilized for the participants are not a reliability tested instrument. The researcher had to base the interview questions off of previous research, but previous research lacked information in questions regarding rural hospice social work.

**Implications for Clinical Social Work**

As seen previously, rural hospice social workers have a unique situation regarding professional boundaries. Not only do hospice social workers have a very emotional line of work which creates deep connections with hospice clients, but they also experience dual relationships which can have emotional challenges of their own (Cohn & Hastings, 2013; Haxton & Boelk, 2010; Sanders et al., 2012). Along with the dual relationships in the rural community, professionals can feel like they are a professional 24 hours a day.
and can be bombarded with opportunities to breach confidentiality (Cohn & Hastings, 2013; Curtin & Hargrove, 2010; Sanders et al., 2012).

Given all these difficulties for a rural professional, the professional needs to engage in an self-awareness process of their own boundary challenges (Davidson, 2004; Sanders et al., 2012). Each professional is shaped by their environment and has strengths and limitations so self-awareness is of the utmost importance. One participant stressed the significance of recognizing feelings regarding certain patients such as feeling “too comfortable” in a client’s house and really “clicking” with certain families. These feelings in and of themselves are not detrimental, but recognition of their existence is key. Davidson (2004) suggests understanding influences of past and current experiences, personal developmental process of professional boundaries, and identifying personal areas of vulnerability as keys to self-awareness.

Even though very little literature gives directions on how to manage dual/multiple relationships, these challenges can often be shared with someone in supervision (Boys & Pope, 1989; Kagle & Giebelhausen, 1994; Reamer, 2003). Rural professionals, especially in hospice, should attempt to find good supervision since the literature and participants’ shared good supervision can help prevent professional boundary breaches and violations (Boys & Pope, 1989; Kagle & Giebelhausen, 1994; Reamer, 2003). Given technology has made communication easier, rural hospice social workers can connect with professionals further away in order to have good supervision with someone who understands the challenges of rural practice (Davidson, 2004).

The challenges of rural hospice social work seem to be very pertinent; professionals need to find the strengths of working in a rural community. Participants
reported that they felt their work was meaningful and important despite all the challenges. The literature and this research discuss that the rural community members care for one another and show genuine concern for members especially those at end of life (Sanders et al., 2012). Participants felt that the community was learning the importance of confidentiality and understood the reason for not being able to share information.

Rural hospice social workers face many challenges but these challenges can be alleviated by having an understanding of professional boundaries and one’s own boundary issues. Along with self-awareness, a professional can utilize quality supervision especially with new technological advances in communication. It is important to find supervision that truly understands the intricate interplay of the rural community and hospice social work. Finally, professionals need to find meaning in their work in hospice and strengths within the rural community.

**Implications for Future Research**

Even though some research has been performed in the realm of rural hospice social work and hospice professional boundaries, there is a lack of research performed with both aspects combined (Haxton & Boelk, 2010; Sanders et al., 2012). Past research discusses professional boundaries within a rural community are different but does not outline best practice in rural community boundaries (Cohn & Hastings, 2013; Davidson, 2005). Even though it shows the professional boundaries are different in the rural community, it does not discuss how this directly impacts the professionals within hospice agencies (Sanders et al., 2012). The research that has been done is qualitatively and no quantitative data has been established (Sanders et al., 2012).
Given the information that participants shared about dual/multiple relationships as prevalent in rural hospice social work and lack of consensus on how to manage dual/multiple relationships, it is of the utmost importance that this area of social work be researched (Boys & Pope, Haxton, & Boelk, 2010; Davidson, 2005; Reamer, 2003; Sanders et al., 2012) Participants articulated how they were unsure how to manage these relationships even though the relationships were happening. Professionals need guidance on these relationships especially within hospice as dual/multiple relationships are not only experienced with the client but also the family of the client. This expansion of possible dual relationships increases the likelihood of having a dual/multiple relationship as compared to the one on one counseling relationship. Also, hospice social workers, as time goes along, will increase the likelihood of encountering dual/multiple relationships the longer they remain a hospice social worker and working in the same community (Haxton & Boelk, 2010).

Exploration of the process of debriefing for hospice professionals needs to be performed. The findings in this study support this process as helpful to the participants in this study as a way to maintain professional boundaries. More research needs to be accomplished in terms of the most constructive format for hospice professionals and if a unique formats needs to be conducted for rural hospice professionals and its tie to what part of the process is most beneficial for these communities.

Much of the literature focuses on the negativity of the rural community. Participants shared that dual/multiple relationships can allow rapport to build quickly due to the already established relationship. This quick rapport building could be a benefit to rural hospice social workers as often; time is of the essence with clients who are dying.
The research does not discuss these benefits especially not in a quantitative manner so more research needs to be organized in this sector to see if this would benefit rural hospice social workers.

For future research, the area of rural hospice social work needs to be expanded especially focusing on the needs of the rural community in a quantitative manner (Haxton & Boelk; 2010; Sanders et al., 2012) More emphasis should be directed towards dual/multiple relationships because as time goes on a rural hospice social worker may encounter these more frequently as the number of clients and families that they serve increase (Sanders et al., 2012). Also, participants voiced that dual/multiple relationships can allow for rapport building to happen more quickly with hospice patients and due to time constraints with these relationships, exploring how this can benefit or hinder clients is very important also.

**Conclusion**

In conclusion, this research adds valuable information in regards to rural hospice social work and professional boundaries. Much of the literature focuses on professional boundaries in rural community or hospice social work but very few studies combine the two aspects. The findings add valuable information regarding the prevalence of dual relationships within rural hospice social work and how hospice professionals cope with the challenges in the rural community. Similarly, the research solidified the importance of self-awareness, self-care, and more education on the topic of rural boundaries.

The challenge of rural hospice social work can be seen in this research. Rural hospice social workers struggle with the macro- aspects of their work such as lack of anonymity and challenges with confidentiality. Along with those challenges they
encounter micro-challenges with dual/multiple relationships and a high emotional connection to clients and families. It feels as though these social workers are faced with double boundary challenge with the community and with clients. Given this dual difficulty of hospice social workers, the necessity of good supervision and more education on the topic of professional boundaries is essential in rural communities. Although, education and supervision is not enough as professionals in this field also need better guidelines to follow concerning professional boundaries. Given the debate on appropriate professional boundaries in the rural communities, more research needs to be performed in this area in order to better equip both professionals in the field and also future practitioners in the rural community.
References


Claxton-Oldfield, S., Gibbon, L., & Schmidt-Chamberlain, K. (2011). When to say "yes" and when to say "no": Boundary issues for hospice palliative care volunteers.
American Journal of Hospice and Palliative Medicine, 429-434.
doi:10.1177/1049909110397926


Appendix A: Agency Consent Form

Agency CONSENT FORM

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

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

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Boundaries, Hospice, and Rural Community: A Social Worker's Perspective</th>
<th>IRB Tracking Number</th>
<th>539239-1</th>
</tr>
</thead>
</table>

General Information Statement about the study:
The study is looking at hospice social worker's perspective on professional boundaries as it relates to hospice and the rural community. The study involves interviewing these professionals by asking open-ended questions lasting approximately an hour. Confidentiality is of utmost importance and safe-guards have been put in place to maintain confidentiality.

Your agency is invited to participate in this research.
The agency was selected as a host for this study because:
Due to being a hospice program that serves rural community.

Study is being conducted by: Haylee Spronk LSW
Research Advisor (if applicable): Dr. Kari Fletcher
Department Affiliation: Professor of Social Work

Background Information
The purpose of the study is:
The purpose of this study is to explore the social worker's perspective on professional boundaries with in the rural community and hospice.

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

Participants will be asked to engage in a face to face, by phone, or skype interviews at the respondents' convenience. The interview will take approximately 60 minutes long containing open-ended questions. The interview will be digitally recorded on a password protected device with permission from the respondent. This data will then be transcribed by a transcriptionist.
Risks and Benefits of being in the study
The risks involved for subjects participating in the study are:
There are minimal risk to the respondents.

The direct benefits the agency will receive for allowing the study are:
There are no direct benefits the agency will receive for allow the study.

Compensation
Details of compensation (if and when disbursement will occur and conditions of compensation) include:
Respondents will receive a $10 gift card from Target for participating.

Confidentiality
The records of this study will be kept confidential. The types of records, who will have access to records and when they will be destroyed as a result of this study include:
The type of records include: audio-recordings, transcriptions, consent forms, and computer records. The audio-recordings will be performed on a smartphone device which is password protected and will be downloaded to a password protected computer. The audio-recordings will then be deleted off the smartphone device. The rest of the records will be stored on a password protected computer in which only the researcher has access to. The records will be destroyed as of July 31st, 2014.

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

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

Contacts and Questions
You may contact any of the resources listed below with questions or concerns about the study.
Researcher name | Haylee Spronk
Researcher email | abc@abc.com
Researcher phone | 555-5555
Research Advisor name | Dr.Kari Fletcher
Research Advisor email | kari.fletcher@stthomas.edu
**Statement of Consent**

I have read the above information. My questions have been answered to my satisfaction and I consent to allow the study to be conducted at the agency I represent. By checking the electronic signature box, I am stating that I understand what is being asked of me and I give my full consent.

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<thead>
<tr>
<th>Signature of Agency Representative</th>
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<tbody>
<tr>
<td>Haylee Spronk</td>
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</table>

*Electronic signatures certify that:

- The signatory agrees that he or she is aware of the policies on research involving participants of the University of St. Thomas and will safeguard the rights, dignity and privacy of all participants.
- The information provided in this form is true and accurate.
- The principal investigator will seek and obtain prior approval from the UST IRB Office for any substantive modification in the proposal, including but not limited to changes in cooperating investigators/agencies as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study which may affect the risks and benefits to participation will be reported in writing to the UST IRB Office and to the subjects.
- The research will not be initiated and subjects cannot be recruited until final approval is granted.
Appendix B: Recruitment E-mail/Letter for Participant or Agency

Dear (Potential Participant),

My name is Haylee Spronk and I am a Master’s student in the School of Social Work at the University of St. Thomas and St. Catherine University of St. Paul, MN. I am currently conducting research under the supervision of Dr. Kari Fletcher. As part of my research, I am conducting interviews with hospice social workers who work in a rural community to discover their perspective on professional boundaries.

I received your name and credentials from your hospice website or through contacting the administrator of the hospice facility. I understand that you currently work as a hospice social worker in a rural community. I would like to speak with you about your perspective on professional boundaries as it relates to hospice and the rural community.

Background Information:

- The interview would last approximately 1 hour, and would be arranged for a time convenient for your schedule.
- Involvement in this interview is entirely voluntary and there are no known or anticipated risks or benefits for your participation in this study.
- You may decline to answer any of the interview questions you do not wish to answer and may terminate the interview at any time.
- With your permission, the interview will be tape-recorded to facilitate collection of information and later transcribed verbatim for analysis.
- All information you provide will be considered confidential.
- The data collected will be kept in a secure location and disposed of on July 31, 2014.
- If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please feel free to contact myself at or my supervising chair, Dr. Kari Fletcher at (651) 962-5807.
- I would like to assure you that this student has been reviewed and received ethics clearance through the Internal Review Board (IRB) at the University of St. Thomas and St. Catherine University of St. Paul, MN. However, the final decision about participation is yours.
- After all the data has been analyzed, the findings will be published as well as orally presented at St. Catherine’s University of St. Paul, Minnesota.

With your permission, I would like to call you in 2-3 days to see if you are interested in being interviewed. Once again, if you have any questions or concerns please do not hesitate to contact me on my confidential cell phone at 555-5555.

Thank-you for your consideration,

Haylee Spronk, LSW
Graduate Student
Appendix C: Recruitment Telephone Script

Telephone Script
P=Potential Participant
I=Interviewer
I-May I please speak to [name of potential participant]?
P-Hello, [name of potential participant] speaking. How may I help you?
I-My name is Haylee Spronk and I am a Master’s student in the School of Social Work at the University of St. Thomas and St. Catherine’s University of St. Paul, MN. I am currently working on conducting research under the supervision of Dr. Kari Fletcher on professional boundaries of rural hospice social workers. As a part of my research, I am conducting interviews with rural hospice social workers to discover their perspectives on professional boundaries.
I received your name and credentials from your hospice website or through contacting the Administrator of the hospice facility. I understand that you currently work as a hospice social worker in a rural community. I would like to speak with you about your perspective on professional boundaries as well as how you manage that in a rural community. Is this a convenient time to ask you a few questions and provide you with further information about the study and interview process?
P-No could you call back later? (Agree on a more convenient time to call person back). OR
P-Yes
I-I would like to verify that you meet the expectations required for this particular study? Have you worked in hospice for at least a year? Are you currently working for hospice? Do you work in [county] which is considered a rural county? Would you consider yourself a good candidate for this study? Why or why not?
I-background information: I will be undertaking interviews starting January of 2012. The interviews will last about 45 minutes-1 hour and will be audio recorded to facilitate collection of information and later transcribed verbatim for analysis. Involvement in this interview is entirely voluntary and confidentiality is ensured. The questions will focus on your experience with professional boundaries, difficulty with managing boundaries in the hospice setting, and the influence on the rural community on professional boundaries. The interview with your permission, I would like to email/mail/fax you an information letter which has all of these details along with contact names and numbers on it to help assist you in making decision about your participation in this study.
P-No thank-you OR
P-Sure (get contact information from potential participant i.e mailing address/fax number).
I-Thank you very much for your time. May I call you in 2 to 3 days to see if you are interested in being interviewed? Once again, if you have any questions or concerns please do not hesitate to contact me on my confidential cell phone at 555-5555
P-Good-bye
I-Good-bye
A study on professional boundaries for Rural Hospice Social Workers

The goal of this study is to explore social worker’s perspective on professional boundaries in rural hospice.

- Participants will complete one audio-taped interview lasting approximately 1 hour
- Interview will include questions asking about your perspective on professional boundaries in hospice and rural community.
- This study can be done either in-person, telephone, or even via Skype
- You may be able to participate in this study if you...

  Are a licensed hospice social worker with at least 1 year of experience and practices in a rural community?

For more information, contact:
Haylee Spronk
555-5555

Appendix D: Recruitment Flyer
Appendix E: Resource List for Southwest Minnesota, Northwest Iowa, and Southeast South Dakota

Southwest MN:
Southwestern Mental Health Services
Luverne
216 East Luverne Street
Luverne, MN 56156
Phone: (507) 283-9511
Fax: (507) 283-9514
Pipestone
1016 8th Avenue SW
Pipestone, MN 56164
Phone: (507) 825-5888
Fax: (507) 825-5880
Worthington
1210 5th Avenue
Worthington, MN 56187
Phone: (507) 376-4141
Fax: (507) 376-4494
Jackson
401 West Street, Suite 0115
Jackson, MN 56143
Phone: (507) 847-2423
Fax: (507) 847-2422
Windom
41385 US Highway 71 North
Windom, MN 56101
Phone: (507) 831-2090
Fax: (507) 831-0185

Western Mental Health
Marshall (Clinical Offices)
1212 East College Drive
507-532-3236
Redwood Falls
205 S. Mill St.
507-637-3340
Slayton
3001 Maple Road
507-836-6053
Canby
112 St. Olaf Ave. S
507-223-7221

Northwest IA:
The Seasons Center
201 East 11th Street
Spencer, IA 51301
Emmetsburg
717 Broadway
(800) 242-5101
Estherville
115 North 6th Street
(800) 242-5101
Paulina
5616 460th Street
(800) 242-5101
Rock Rapids
315 1st Avenue
(800) 242-5101
Sheldon
604 Park Street
(800) 242-5101
Sibley
600 North 9th Avenue
(800) 242-5101
Spirit Lake
2301 Highway 71
(800) 242-5101
Storm Lake
715 West Milwaukee
(800) 242-5101

Southeast SD:
Great Plains Psychological Services
4105 S Carnegie Pl
Sioux Falls, SD 57106
(605) 323-2345
Southeastern Behavioral Health Center
2000 S Summit Ave
Sioux Falls, SD 57105
(605) 413-1519

Hospice Resources:
National Hospice and Palliative Care Organization
http://www.nhpco.org
(703)-837-1500
Social Work Hospice and Palliative Care Network
http://www.swhpn.org/
American Academy of Hospice and Palliative Medicine
http://www.aahpm.org/
National Hospice Foundation
http://www.nationalhospicefoundation.org
(877) 470-6472
Hospice Foundation of America
http://www.hospicefoundation.org/
(800) 854-3402
Minnesota Hospice and Palliative Care
http://mnhpc.org/
(800)-214-9597
Hospice and Palliative Care Association of Iowa
http://www.hpcai.org/
(515)-243-1046
South Dakota Association of Health Care Organizations
http://www.sdaho.org/
(605) 361-2281
Social Worker’s Perspective: Boundaries within Hospice and the Rural Community

539239-1

I am conducting a study about rural hospice social work and professional boundaries. I invite you to participate in this research. You were selected as a possible participant because of your expertise in the hospice field and your practice in a rural community. Please read this form and ask any questions you may have before agreeing to be in the study.

Background Information:
Professional boundaries are a necessary part of the social work profession. These boundaries can help or hinder the professional relationship. It is important to understand the experiences of social workers currently practicing in the field in order to understand professional boundaries. Since hospice is highly emotional and the rural community may have different boundaries, the purpose of this study is to understand how social workers are navigating these challenges.

If you agree to be in this study, I will ask you to do the following things: Respondents will be asked to engage in a face to face interview at the respondents’ convenience. The interview will take approximately 60 minutes long containing open-ended questions. The interview will be digitally recorded on a password protected device with permission from the respondent. This data will then be transcribed by a transcriptionist

Risks and Benefits of Being in the Study:
There are minimal risks for participating and no benefits to participating in this study.

Compensation:
You will receive a $10 gift card to target for your participation.

Confidentiality:
The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include audio recording, transcriptions and computer records. Audio recording will be downloaded to a password protected computer along with transcription files and computer records. The audio files will then be deleted from password protected device after being downloaded. All these records will be destroyed as of July 31st, 2014. The computer files are only accessible to the researcher.

Voluntary Nature of the Study:
Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas/St. Catherine University. If you decide to participate, you are free to withdraw at any time up to and until February 1st, 2014. Should you decide to withdraw data collected about you, we will not use your data. You are also free to skip any questions I may ask.

Contacts and Questions
My name is Haylee Spronk. You may ask any questions you have now. If you have questions later, you may contact me at 555-5555 or my advisor Dr. Kari Fletcher at (651) 962-5807. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

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

Statement of Consent:
I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I consent to being digitally audio-recorded.

______________________________   ________________
Signature of Study Participant     Date

____________________________________
Print Name of Study Participant

______________________________   ________________
Signature of Researcher     Date
Appendix G: Research Questions

1. Can you tell me a little bit about your job?

**Defining:**
2. How do you describe professional boundaries?
3. What are the importance of professional boundaries?

**Micro:**
4. What does professional boundaries look like for you regarding relationships with hospice patients?
5. How do professional boundaries differ between professionals within your agency?
6. How do you know when professional boundaries are being breached or violated?

**Mezzo:**
7. How do you maintain boundaries between work and home life?
8. What are boundary challenges in hospice?
9. Are there ways an agency either helps or hinder professional boundaries?

**Macro:**
10. How are your professional boundaries affected by the rural community you practice in?
11. Have you ever experienced a dual relationship? If so how did you navigate it?
12. Can you think of an example of how professional boundaries impact relationships either positively or negatively?

**Other Questions:**
13. Is there anything else you would like to add to this topic?
14. Can you name another social worker who may be interested in participating in this research project?