

# PROFESSIONAL BOUNDARIES IN HEALTH-CARE RELATIONSHIPS

*The Client Relations Committee of the College is charged with the responsibility for the development, implementation and ongoing updating of the College's mandatory Sexual Abuse Prevention Program. The program must include educational components for members, guidelines for the conduct of members with their clients, training for College staff and the provision of information to the public. In meeting its mandate, the Client Relations Committee has participated in the Barbara Wand Symposium, annually presents at the Ontario Psychological Association conference and as well, produces written material for members and the public. The following article was developed by the Client Relations Committee and is published for the education and guidance of members. It will also be reproduced and routinely provided to all new members issued with Certificates Authorizing Supervised Practice and their supervisors, and will be available to course instructors, students and others, upon request. It is also available on the College website.*

The Client Relations Committee of the College has been reviewing this complex, sensitive area in an effort to assist members in their understanding and management of boundary issues in professional practice. It is evident that the majority of members treat their clients respectfully, compassionately and responsibly and would not knowingly compromise the professional relationship established with them. This does not mean that relationship dilemmas or difficult situations do not arise.

The following article discusses the nature of the professional relationship, provides information to help members recognize potential problem situations, and suggests some strategies to consider in managing professional boundaries.

## *Characteristics of Professional Boundaries*

Boundaries are the framework within which the therapist/client relationship occurs. Boundaries make the relationship professional, and safe for the client, and set the parameters within which psychological services are delivered. Professional boundaries typically include fee setting, length of a session, time of session, personal disclosure, limits regarding the use of touch, and the general tone of the professional relationship. In a more subtle fashion, the boundary can refer to the line between the self of the client and the self of the therapist.

The primary concern in establishing and managing boundaries with each individual client must be the best interests of the client. Except for behaviours of a sexual nature or obvious conflict of interest activity, boundary considerations often are not clear-cut matters of right and wrong. Rather, they are dependent upon many factors and require careful thinking through of all the issues, always keeping in mind the best interests of the client.

## ***Who Negotiates the Boundaries in the Professional Relationship***

In any professional relationship there is an inherent power imbalance. The therapist's power arises from the client's trust that the therapist has the expertise to help with his or her problems, and the client's disclosure of personal information that would not normally be revealed. The fact that services cannot be provided unless clients are willing to cooperate, does not change the fundamental power imbalance. Therefore, the therapist has a fiduciary duty to act in the best interest of the client, and is ultimately responsible for managing boundary issues and is therefore, accountable should violations occur. Given the power imbalance that is inherent in the professional/client relationship, clients may find it difficult to negotiate boundaries or to recognize or defend themselves against boundary violations. As well, clients may be unaware of the need for professional boundaries and therefore, may at times even initiate behaviour or make requests that could constitute boundary violations.

### ***Typical Areas Where it May Be Difficult to Draw A Line or Where Boundaries Can Become Blurred***

There are a number of areas in which one has to maintain boundaries, that is, draw a line. Below are some typical areas that can present difficulties.

**Self disclosure.** Although in some cases self disclosure may be appropriate, members need to be careful that the purpose of the self disclosure is for the client's benefit. A number of dangers may exist in self disclosure including shifting the focus from the needs of the client to the needs of the therapist or moving the professional relationship toward one of friendship. The blurring of boundaries can confuse the client with respect to roles and expectations. The primary question to be asked is, "Does the self disclosure serve the client's therapeutic goal?"

**Giving or receiving significant gifts.** Giving or receiving gifts of more than token value is contrary to professional standards because of the risk of changing the therapeutic relationship. For example, a client who receives a gift from a member could feel pressured to reciprocate to avoid receiving inferior care. Conversely, a member who accepts a significant gift from a client risks altering the therapeutic relationship and could feel pressured to reciprocate by offering "special" care.

**Dual and overlapping relationships.** *Dual relationships* should be avoided. These occur in situations where the member is both the clinician and also holds a different significant authority or emotional relationship with the same person. Examples can include course instructor, work place supervisor, or family member. Members need to remain cognizant that the purpose of avoiding dual relationships is to avoid exploiting the inherent power imbalance in the therapeutic relationship. *Overlapping relationships*, while potentially problematic, may not always be possible to avoid. Overlapping relationships, where a member has contact, but no significant authority or emotional relationship with the client, may occur particularly for therapists who are members of small communities, or for clinicians who work with a particular client population with which they are also

affiliated. Such overlapping relationships can occur in situations where, for example; the client is a member of a particular religious or ethnic group and tends to practice within this community; the therapist is gay or lesbian and works with gay or lesbian clients; or, the member has a child with a learning disability, is active in a local association, and also does learning disability assessments. Situations where there may be overlapping relationships need to be judged on a case by case basis.

Members should avoid relationships with their clients outside of therapy where either the therapist or client is in a position to give a special favour, or to hold any type of power over the other. For example, some situations to be avoided include employing a client or his or her close relatives, involving oneself in business ventures where one could benefit financially from a client's expertise or information, or engaging in therapy or assessment with a current student. Similarly, members should refrain from requesting favours from clients, such as baby-sitting, typing, or any other type of assistance that involves a relationship outside therapy.

**Becoming friends.** Generally, members should avoid becoming friends with clients and should refrain from socializing with them. Although there are no explicit guidelines that prohibit friendships from developing once therapy has terminated, members must use their clinical judgment in assessing the appropriateness of this for the individual client. Potential power imbalances may continue to exist and influence the client well past the termination of the formal therapeutic relationship.

In the course of therapy, some clinicians, on occasion, may engage in activities that resemble friendship, such as going on an outing with a child or adolescent, or attending a client's play, wedding, or special event. In all cases it is the clinician's responsibility to ensure that the relationship remains therapeutic and does not develop into a friendship or a romantic involvement. The definition of "sexual abuse" within the legislation makes it clear that it is unacceptable to date a current client. Since power imbalances may continue to influence the client well past termination, professional standards prohibit a member from engaging in a sexual relationship with a former client to whom any professional service was provided in the past two years. Members are reminded that even the most casual dating relationship may lead to forms of affectionate behaviour that could fall within the definition of sexual abuse.

**Maintaining established conventions.** Ignoring established conventions that help to maintain a necessary professional distance between clients and members can lead to boundary violations. Examples include providing treatment in social rather than professional settings, not charging for services rendered, not maintaining clear boundaries between living and professional space in home offices, or scheduling appointments outside of regular hours or when no one else is in the office.

**Physical contact.** There are a variety of ways of using touch to communicate nurturing, understanding and support such as a pat on the back or shoulder, a hug or a handshake. Such touch can however, also be interpreted as sexual or inappropriate which necessitates careful and sound clinical judgment when using touch for supportive or therapeutic

reasons. Clinicians must be cautious and respectful when any physical contact is involved, recognizing the diversity of cultural norms with respect to touching, and cognizant that such behaviour may be misinterpreted.

Diagnostic and therapeutic work with children requires special consideration. Some agencies or institutions for example, advise their staff to avoid any touching of children. In other settings however, touching may be permitted, and this would ordinarily be open to public scrutiny. In working with children and considering the question of touching, one might ask, "Would I do this in the presence of my colleagues or this child's parents?" Again, good clinical judgment should prevail for the protection of both the client and the practitioner.

Some clinical situations such as neuropsychological testing and biofeedback, or clinical interventions such as bioenergetics, require touching the client. When such touch is necessary, it is important to explain this to the client and ensure the client's understanding, and the client's fully informed consent. If there is concern that a particular client may misinterpret a therapist's actions, members may wish to have someone else present in the session, consider an alternate treatment approach, or think about a referral to another practitioner.

### ***Questions to Consider in Examining Potential Boundary Issues***

In each individual case, boundary issues may pose dilemmas for the clinician and there may be no clear or obvious answer. In determining how to proceed, consideration of the following questions may be helpful.

- Is this in my client's best interest?
- Whose needs are being served?
- Will this have an impact on the service I am delivering?
- Should I make a note of my concerns or consult with a colleague?
- How would this be viewed by the client's family or significant other?
- How would I feel telling a colleague about this?
- Am I treating this client differently (e.g., appointment length, time of appointments, extent of personal disclosures)?
- Does this client mean something 'special' to me?
- Am I taking advantage of the client?
- Does this action benefit me rather than the client?

- Am I comfortable in documenting this decision/behaviour in the client file?
- Does this contravene the Regulated Health Professions Act, the Standards of Professional Conduct or the Code of Ethics, etc.?

### ***Boundary Violations and Sexual Abuse***

Sexualizing a professional, health-care relationship is against the law. In Ontario, the Regulated Health Professions Act (RHPA) prohibits sexual involvement of health-care professionals with clients. The RHPA[1(3)] defines sexual abuse broadly as: sexual intercourse or other forms of physical sexual relations between a member and a client; touching, of a sexual nature of the client by the member; or, behaviour or remarks of a sexual nature by a member toward a client.

There are **NO** circumstances in which sexual activity between a psychologist or psychological associate and a client is acceptable. Sexual activity between a client and practitioner is always detrimental to client care, regardless of what rationalization or belief system the health-care professional chooses to use to excuse it. Because of the unequal balance of power and influence, it is impossible for a client to give meaningful consent to any sexual involvement with his or her therapist; client consent and willingness to participate in a personal relationship does not relieve the member of his or her duties and responsibilities for ethical conduct in this area. Failure to exercise responsibility for the professional relationship and allowing a sexual relationship to develop is an abuse of the power and trust which are unique and vital to the therapist/client relationship.

### ***Warning Signs***

There may be times in the practice of psychology when a member could find himself or herself drawn toward a client or could experience feelings of attraction to a client. It is vital that the psychologist or psychological associate recognize these feelings as early as possible and take action to prevent the relationship from developing into something other than a professional one. If a client attempts to sexualize the relationship, the obligation is always on the psychologist or psychological associate not to cross the line.

Research has shown that before actual physical contact or abuse occurs there are often a number of warning signs, or changes in the therapist's behaviour. Members should be alert to such signs that suggest he or she may be starting to treat a particular client differently. These may include sharing personal problems with the client, offering to do therapy in social situations such as over dinner, offering to drive a client home, not charging for therapy, or making sure the client's appointments are scheduled when no one else is in the office.

In addition, miscommunication between a psychologist or psychological associate and a client may cause the client to misunderstand a member's intent. While it may seem harmless to make a personal compliment about a client's appearance, or tell a 'racy' joke,

this type of behaviour can be misinterpreted by a client as an interest in him or her personally.

### *Prevention and Avoidance of Sexual Misconduct*

The best way to maintain the appropriate boundaries in a professional/client relationship is through the clinician's focus on maintaining good, personal psychological health, an awareness of potential problems and good, clear communication. One's power and control over a client should not be underestimated. One should also remain aware that the client may experience touch, personal references and sexual matters very differently from the clinician due to a variety of factors including gender, cultural or religious background, or personal trauma such as childhood sexual abuse. Risky situations should be avoided and the proper boundaries of any professional/client relationship should be communicated clearly and early in the treatment process. The following guidelines suggest approaches to prevent boundary violations and avoid complaints of sexual misconduct.

1. Respect cultural differences and be aware of the sensitivities of individual clients.
2. Do not use gestures, tone of voice, expressions, or any other behaviours which clients may interpret as seductive, sexually demeaning, or as sexually abusive.
3. Do not make sexualized comments about a client's body or clothing.
4. Do not make sexualized or sexually demeaning comments to a client.
5. Do not criticize a client's sexual preference.
6. Do not ask details of sexual history or sexual likes/dislikes unless directly related to the purpose of the consultation.
7. Do not request a date with a client.
8. Do not engage in inappropriate 'affectionate' behaviour with a client such as hugging or kissing. Do offer appropriate supportive contact when warranted.
9. Do not engage in any contact that is sexual, from touching to intercourse.
10. Do not talk about your own sexual preferences, fantasies, problems, activities or performance.
11. Learn to detect and deflect seductive clients and to control the therapeutic setting.
12. Maintain good records that reflect any intimate questions of a sexual nature and document any and all comments or concerns made by a client relative to alleged sexual

abuse, and any other unusual incident that may occur during the course of, or after an appointment.

### ***What Members Can Do?***

If a member finds himself or herself having a problem with how he or she is treating or feeling about a client or how clients are feeling about them, members should get assistance as soon as possible. If the client has been sexualizing the relationship, this should be documented, as should actions taken to diffuse the situation. Members are encouraged to talk to a trusted colleague or mentor, seek professional help from a qualified practitioner in the psychological community or elsewhere, or call the practice advisory service at the College.

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<http://www.cpo.on.ca/Bulletin/Selected%20Articles/Professional%20Boundaries.htm>