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**PROFESSIONAL BOUNDARIES
in Health-Care Relationships**

Professional boundaries (or issues surrounding professional boundaries) in therapeutic relationships are frequently the cause of client complaints to the College. In fact, 56% of complaints received and forwarded for disciplinary hearings over the past ten years have had to do, one way or the other, with a blurring or “breach” of professional boundaries.

The following article, which originally appeared in the College of Psychologists of Ontario BULLETIN (Volume 25, No. 1, July 1998) and is being reprinted with permission, clarifies potential problems with professional relationships and poses some questions to consider in examining boundary issues. This is the first part of the article, the second part will be published in the Fall 2000 issue of the The CAP Monitor.

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 interests 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 the 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 judgement 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 services 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 judgement 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 considerations. 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.?

Watch for the second part of this article in the Fall 2000 issue.