

# Being clear about boundaries

**Jonathan Coe** outlines an initiative designed to raise awareness of boundary violations, and provides some tips for practitioners on managing boundaries

One of the most challenging areas of practice is the art of establishing and maintaining professional boundaries. This is an area in which WITNESS has been working since it was founded as the Prevention of Professional Abuse Network (POPAN) in the early 1980s. It is also an area that has attracted increasing attention following a series of reports into abusive behaviour by health professionals in recent years. In response to these inquiries, the Council for Healthcare Regulatory Excellence (CHRE), funded by the Department of Health, has recently developed new information about sexual boundaries as part of its 'Clear Boundaries Project'.

## Clear Boundaries Project

The CHRE Clear Boundaries Project was developed in the context of the White Paper, *Trust, assurance and safety: the regulation of health professionals in the 21st century*<sup>1</sup>. The accompanying document, *Safeguarding patients*<sup>2</sup>, includes a chapter on boundary transgressions. The Clear Boundaries Project encompassed an extensive literature research survey, culminating in a report with recommendations on professional training and education, information for patients and regulators and information for registered practitioners<sup>3</sup>.

Among the recommendations of the Clear Boundaries Project is that regulator panels that undertake

inquiries into the fitness to practise of registrants (eg the General Medical Council or Health Professions Council) should be properly trained in understanding the dynamics of boundary violations by healthcare professionals. An understanding of the dynamics of power, dependency and trust in professional relationships is seen as essential when coming to judgment in such cases.

## Research

The project's review of the empirical research literature<sup>4</sup> between 1970 and 2006 on abuse by health workers found unequivocal evidence of harm to patients/clients related to sexual boundary violations. Key findings were that:

- sexual boundary violations by health employees commonly result in significant and enduring harm

(eg see box below)

- clear sexual boundaries are crucial to patient/client safety
- the majority of reported sexual boundary violations involve male employees and female victims
- client vulnerability is associated with a higher prevalence of boundary violations
- a greater awareness of guidelines and sanctions, and targeted educational and training programmes reduce prevalence rates.

## Training and education

The CHRE report revealed that training on professional boundaries is frequently not provided either at graduate level or as part of continuing professional development. The survey of training institutions that was conducted as part of the project found almost universal support among

## Sexual boundary violations by professionals commonly result in significant and enduring harm

Kenneth Pope<sup>5</sup> lists the following symptoms as common in people who have had sexual contact with their therapist, but not appearing always and in each person.

- Ambivalence/psychological paralysis
- Cognitive dysfunction
- Emotional lability
- Emptiness and isolation
- Guilt
- Impaired ability to trust
- Increased suicide risk
- Role reversal and boundary disturbance
- Sexual confusion
- Suppressed anger

respondents for introducing this element into teaching programmes. The report notes particular areas of focus for education and outlines some possible methods for effective learning. Such training should cover: the differences between personal and professional relationships, the differences between boundary

crossings and boundary violations, the dynamics of abuse, the 'slippery slope' of boundary violations, and the spectrum of professional behaviour, from bounded, professional therapeutic behaviour at one end to severe boundary breaches, unprofessional and non-therapeutic behaviours at the other. This core

training has recently been undertaken by some statutory regulators as well as NHS and social care providers.

### Guidance and information

The CHRE project documentation<sup>6</sup> includes definitions of sexual boundary violations, describes the damage they cause, and provides guidance on the

ALL THERAPISTS (n = 84)	
	<b>DISCIPLINE</b>
	Psychotherapist    Counsellor    Psychologist    Hypnotherapist
number of patients	41                    27                    9                    7
per cent	48.8                  32.1                  10.7                8.3
	<b>BOUNDARY TYPE</b>
	Sexual              Psychological      Financial
number of patients	31                    59                    3
per cent	33.3                  63.4                  3.2
	<b>SETTING</b>
	Private practice    Centre/NHS
number of patients	51                    20
per cent	71.8                  28.2
	<b>GENDER</b>
	Female              Male
number of patients	29                    49
per cent	37.2                  62.8
	<b>Boundary type</b>
	Psychotherapist    Counsellor      Psychologist      Hypnotherapist
<b>Sexual</b>	
number of patients	12                    12                    4                    3
per cent	38.7                  38.7                  12.9                9.7
<b>Psychological</b>	
number of patients	30                    17                    8                    4
per cent	50.8                  28.8                  13.6                6.8
<b>Financial</b>	
number of patients	2                      1                      0                      0
per cent	66.7                  33.3                  0                      0

Table 1. Boundary violation reports to the WITNESS helpline, 2005/06

responsibilities of healthcare workers as well as possible corrective actions they and their organisations can take.

There is now almost universal agreement that sexual relationships between healthcare workers and their current patients constitute unethical practice, and the guidance is unequivocal on this point. However, there is much less certainty about the situation regarding former patients, and the guidance takes a line that stops short of zero tolerance, instead recommending a balanced approach where sanctions should be proportionate to the vulnerability of the patient and should relate to the particular nature of the professional relationship.

### The work of WITNESS

WITNESS has been a member of the CHRE Clear Boundaries Project board as well as a member of the Health Professions Council professional liaison group on psychological therapy and an advisor on regulation to the 'We Need to Talk' campaign<sup>7</sup>. WITNESS works to promote safe boundaries between professionals and the public, and to improve public protection through raising awareness, lobbying for improvements in policy, and providing training and education. We also run a helpline for anyone concerned about breaches of trust in health or social care services. The WITNESS helpline routinely takes calls relating to boundary violations by health and social care professionals (see table 1). Calls to the helpline have encompassed a wide range of concerns, including:

- people being encouraged to take no significant decision without their therapist's approval
- sexual contact for 'therapeutic' reasons
- clients undertaking building and reception work for their therapist
- therapy terminated after several years with no warning
- breaking of confidentiality without good cause
- therapist talking about their own problems in a client's session
- sessions extended significantly with no extra charge

- sessions extended with extra charge
- sessions arranged with no charge.

Of course, not all boundary crossings lead inexorably to serious violations. However, such violations become more likely when early boundary challenges are not discussed with the client, or with a supervisor or colleague. Moreover, when serious boundary transgressions occur they are almost always preceded by lesser boundary crossings of various kinds, often in a predictable order. American psycho-analyst and psychiatrist, Robert Simon<sup>8</sup>, provides a useful inventory of this 'slippery slope' (see box right), beginning with changes such as small 'erosions of neutrality', moving gradually into sessions becoming more social and less therapeutic, through self-disclosure and touching to full social or sexual relationship. Some elements of his scheme are not relevant to UK practitioners (who would not, for example, prescribe medication) or practitioners working in less traditional modalities. Also the use of first names would not constitute a boundary crossing for the great majority of practitioners here.

### The 'slippery slope' to boundary violation<sup>8</sup>

1. Therapist's neutrality is eroded in little ways
2. Therapist and patient address each other by first names
3. Therapy sessions become less clinical and more social
4. Patient is treated as 'special' or as a confidant/e
5. Therapist self-discloses, usually about current personal problems and sexual fantasies about the patient
6. Therapist begins touching the patient, progressing to hugs and embraces
7. Therapist gains control over patient, usually by manipulating the transference and/or negligent prescribing of medication
8. Contact occurs outside the therapy sessions
9. Therapy sessions are rescheduled for the end of the day
10. Therapy sessions become extended in time
11. Therapist stops charging a fee
12. Therapist and patient have drinks/dinner together
13. Therapist-patient sex begins



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## Potential non-sexual boundary violations

- Excessive self-disclosure
- Special fee arrangements (low or free)
- Extending time beyond what was initially agreed
- Allowing telephone calls between sessions
- Extra-therapeutic business relationships
- Socialising with the client
- Calling each other by first name
- Treating the patient as a friend or confidant/e
- Touching or frequent hugs

### Grey areas

Clear boundary violations include sexual contact, financial exploitation, breaking confidentiality without good cause, and deliberately fostering dependency. In our experience, twice as many calls to our helpline relate to non-sexual as sexual boundary violations (see box above). However, there can be instances, which are not necessarily clear-cut, in which boundary crossings may be beneficial, depending on the relationship, the situation and their meaning to the client. These might include limited self-disclosure, the use of touch, or contact outside sessions.

There are also situations that give rise to boundary crossings that would not normally occur and would not be seen as harmful – as illustrated in the following two cases.

**Case 1.** After two sessions, practitioner A unexpectedly offers his client a lift to the nearest tube station, saying ‘I wouldn’t do this for everyone’. Some time after the fifth session, the same client reports an achievement and receives a bottle of champagne from the therapist. There are no subsequent similar behaviours and no attempts to seduce.

How might this client have felt? How might the practitioner have felt? How might this have affected the dynamic? What could the practitioner have

done post hoc to attend to the issue?

**Case 2.** Client D reports struggling between her weekly sessions, and feeling that she needs more contact with her counsellor. The counsellor gives her a polished stone, saying, ‘This is to help remind you of me’. The same client gets panicked as her counsellor’s holiday approaches. The counsellor gives the client her mobile number and tells her that she can ring her in Spain if things get very bad.

How might the client feel about this? How would you feel (as a practitioner) if this client came to you for help? What effect might these actions have on the future relationship between this client and her counsellor?

### What can practitioners do?

WITNESS has developed a simple model – the ‘RISC model’ – to help practitioners and supervisors identify areas of possible concern. This provides a framework for examining boundary-crossing behaviours both before and after they may have occurred:

- Role** – the professional’s role
- Impact** – the impact of the behaviour on the client
- Setting** – the context of the work
- Client’s needs** – relevant needs of the client.

Using this model as a starting point, practitioners (and supervisors) may usefully ask themselves following questions:

- Is there a clear reason for this boundary-crossing action based on my client’s need?
- Does my behaviour towards this client differ from my behaviour towards other clients?
- Am I reluctant to discuss some things about my work with this client with my supervisor?
- Am I working beyond my training?
- Am I concerned about how my client may be experiencing my actions?
- Am I checking that my actions are for my client’s benefit?
- What will my action mean to the client?
- What might the effects be?

- Might the client feel ‘special’, different from other clients?
- Will the relationship remain clearly a professional one, or might it become ambiguous and uncertain?

Establishing and maintaining safe boundaries from the first session right through a therapeutic relationship is a key skill, or set of skills. WITNESS would like to see training on professional boundaries embedded in all psychological therapy curricula, so that this skill set is the norm for all practitioners, and the risk of boundary violations is significantly reduced. ■

*Jonathan Coe is the chief executive of WITNESS.*

### References

- 1 Trust assurance and safety – the regulation of health professionals in the 21st century. London: Department of Health; 2007.
- 2 Safeguarding patients. The Government’s response to the recommendations of the Shipman Inquiry’s fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries. London: Department of Health; 2007.
- 3 The CHRE Clear Boundaries project guidance documents are due to be published in January 2008, and will be available via the website at: [www.clearboundaries.co.uk/](http://www.clearboundaries.co.uk/)
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- 6 Available via the Clear Boundaries Project website: [www.clearboundaries.co.uk/](http://www.clearboundaries.co.uk/)
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