

Too close for comfort:

Defining boundary issues in the professional- client relationship

By Claudia Newman, MSW, RSW

Is it okay
to hug a client?

Let us know what you think at
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Have you ever given a client a hug? Accepted a gift from a client? Shared personal information with someone in your care? All of these acts appear innocent and seem harmless. But are they?

Compassion and caring are hallmarks of how we deliver our professional skills. However, our compassion and caring are exactly what may cause us to unwittingly cross the boundaries of the professional-client relationship. And even though it is unwitting, the impact is the same as though the boundary violation was purposeful.

So what can we do to practise prudently without

compromising our compassion? We can

- refresh ourselves about the intent of codes of ethics and what they are there to prevent
- know what gives us our power in our relationship with our clients
- know and understand the definition of a boundary
- understand the shifts that occur in the interpersonal dynamic when we enter into seemingly innocent situations with our clients
- have some tools at our fingertips

Ethical guidelines

If regulated, our professions have regulatory codes of ethics and standards of practice. In addition, our organizations may have codes of ethics or codes of conduct or both. The underlying ethical premise is that the professional service being provided will “do good” and not do harm. However, each of us may interpret the phrase “not do harm” in our own way, based on our own predispositions and values.

In part, *a code of ethics is there to prevent us from bringing our personal values or bias into our ethical decision-making process. Why? Because as soon as our bias enters our decision-making process, our personal views and needs begin to govern or shape the therapeutic intervention. Subsequently, our client’s needs become secondary in the relationship, and as a result, we begin to work from a point of self-gratification.*

Consider the following dilemma as an example: your client lets slip that she is driving despite the fact that her license has been suspended. Many assumptions can be made about this situation. Being human, we may jump to a conclusion based on our own work context. Cognitive impairments or drunk driving are frequent conjectures. Therefore, there is a danger to self and others.

When this scenario is presented to professionals, their responses are twofold: a supposition that they have a legal obligation or a moral obligation to report, or both. If we act on the *supposition* of legal obligation or from our own moral stance, we have automatically let our biases and our needs drive our actions. The self-gratification is that we feel better and have done our “duty,” despite the breach of our client’s confidentiality.

The power imbalance

Many of us have difficulty accepting or “owning” the power that we have in our relationship with our clients. We understand that a power imbalance exists, that our clients come to us vulnerable by virtue of their need for our expert knowledge. However, the word itself is enough to make many of us uncomfortable. When I ask people to tell me what the word “power” means to them, the descriptors fly: control, authority, dominance, inequality. As one registered nurse said, “Why can’t we just name ‘it’ something else?” Despite our discomfort, the reality is that we have power, and there is and always will be a power imbalance between ourselves and our clients.

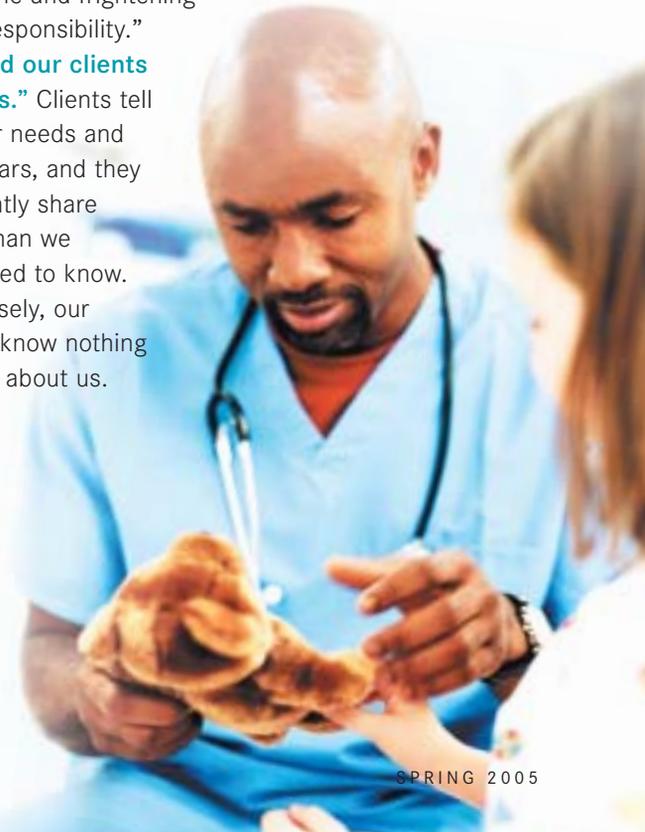
Why is this discussion on power important? Simply, by understanding what gives us our power, we are able to own it and accept it. Without this knowledge, our ethical decision-making process will be flawed when we are faced with an ethical dilemma. Because the answer to the question, “Whose needs are coming first?” is not “my client’s” but “mine.” Consequently, we are already on an ethical slippery slope as our personal values, beliefs and discomforts are

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beginning to define the therapeutic relationship.

What gives us our power? Paraphrasing Marilyn Peterson in her book, *At Personal Risk*, some of the components of power are as follows:

- **Social ascription.** Society grants us the right to use our expert knowledge to help those in need. This right is supported by laws and our social institutions. Entwined with this are the symbols of our power such as uniforms, business cards, and titles. As a paramedic said, “We pull up to a house and knock on the door. They see our uniforms and our ambulance and they let us in. They assume that we are there to help and will do no harm by virtue of the uniforms that we wear.”
- **Our clients’ expectations, both realistic and unrealistic.** Clients’ expectations can be shaped by many things, including previous contact with a health professional, stories of friends’ contact with health professionals and, of course the media.
- **Lack of choice or availability.** You may be the “only game in town” due to geography or specialty. As one occupational therapist (OT) said, “I am the only OT in a 200 kilometre radius. I have the power to put people on my waiting list, take them off, and bump them up or down. The power that I hold is both awesome and frightening in its responsibility.”
- **We hold our clients “stories.”** Clients tell us their needs and their fears, and they frequently share more than we may need to know. Conversely, our clients know nothing or little about us.



■ **With client crises, our power increases.** As a fire chief remarked, “You want to experience the absolute faith and trust that you will do no harm and the giving over of self ... [to] pull someone from a burning wreck.”

These and other elements define our power, creating the power imbalance between ourselves and our clients. We need to own them and accept them as we are solely responsible for managing that differential.

Clear boundaries

One of the simplest definitions of boundaries is provided by Marilyn Peterson, who wrote, “Boundaries are the limits that allow a safe connection based on the client’s needs.” My addition to this definition is that we must not confuse needs with wants. How do we define client needs? We do so through our professional assessment within the context of our job description and within the context and policies of the organization in which we work. If a client need falls outside of this, we refer to the appropriate professional or agency.

An ethical dilemma

Should we hug our clients or do favours for them? Is the answer to each of these questions yes, no, maybe, or dependent upon the circumstance or context?

Consider the following examples: your client is upset and you give them a hug. Or your client gives you a

hug as a thank you for your help. Professionals with whom I’ve worked have varying reactions to this scenario, with circumstance or context being the primary driver of “the hug or not to hug” question. Many argue that touch, including hugs, is important when working in palliative care or with children or in crisis situations. However, is there a shift in the interpersonal relationship by virtue of the touch?

The literature is clear that touch creates a shift in the interpersonal relationship. Generally, we hug or touch our family or friends. Touching or hugging our clients begins to blur the professional-client relationship. Regardless of who initiates the touch, our clients or even we may perceive the relationship as now dual—that of friend and professional—whether we intended it or not. Expectations may be raised that touch is now a norm.

So should we or shouldn’t we hug our clients? We must ask ourselves, why am I hugging my client? What is the purpose of it? Whose needs (not wants) are coming first? Most importantly, we must understand that no matter who initiates the touch, we are totally responsible for managing the shift in the dynamic. There must be a safe connection between ourselves and our client.

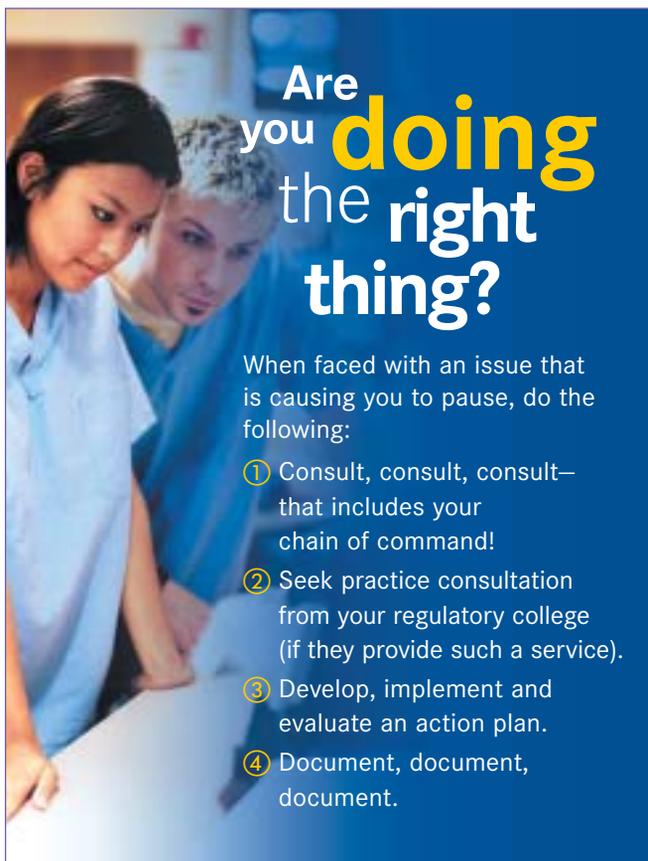
Helpful resources

From a preventative perspective, we can double-check our practices ourselves with the questions below:

- First and foremost, whose needs are coming first?
- Can I explain why I took this course of action? Would a reasonable person in my profession take a similar course of action if faced with the same dilemma?
- Does my action contravene any law, act, professional standard or organizational policy?
- Have I been clear with my client and defined the service parameters and my role?
- Have I terminated my service cleanly; that is, not promised or implied continued availability, thereby building or creating a dependency?
- Do I know my professional strengths and weaknesses?

We are human beings working with other human beings. There will be days when we are tired and stressed. As a result, our ethical decision-making may not be as sound as it is when rested. We may cross boundaries inadvertently, or our clients may innocently push the boundaries. Nevertheless, it is our individual professional responsibility to maintain or re-implement boundaries. Finally, we must take responsibility for our actions; after all, it is the heart of ethical practice. ❖

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Are you doing the right thing?

When faced with an issue that is causing you to pause, do the following:

- ① Consult, consult, consult—that includes your chain of command!
- ② Seek practice consultation from your regulatory college (if they provide such a service).
- ③ Develop, implement and evaluate an action plan.
- ④ Document, document, document.