Alberta College of Speech-Language Pathologists and Audiologists

Hear. Speak. Connect.

Patient Relations Course

Unit 3: Professional Boundaries And Therapeutic Relationships

Handout

Unit 3: Professional Boundaries and Therapeutic Relations

3. Professional Boundaries

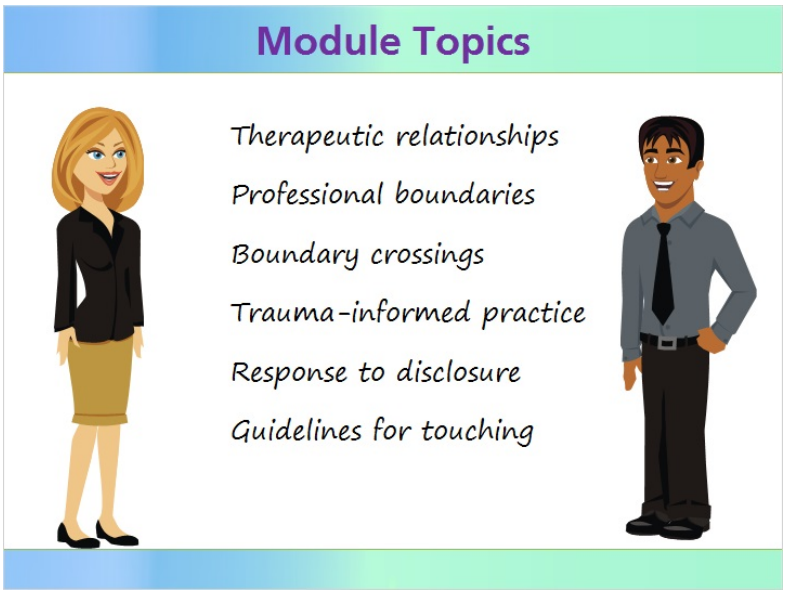
3.1 Welcome

Menu

Narration

No narration, only music.

3.2 Module topics



Menu

Narration

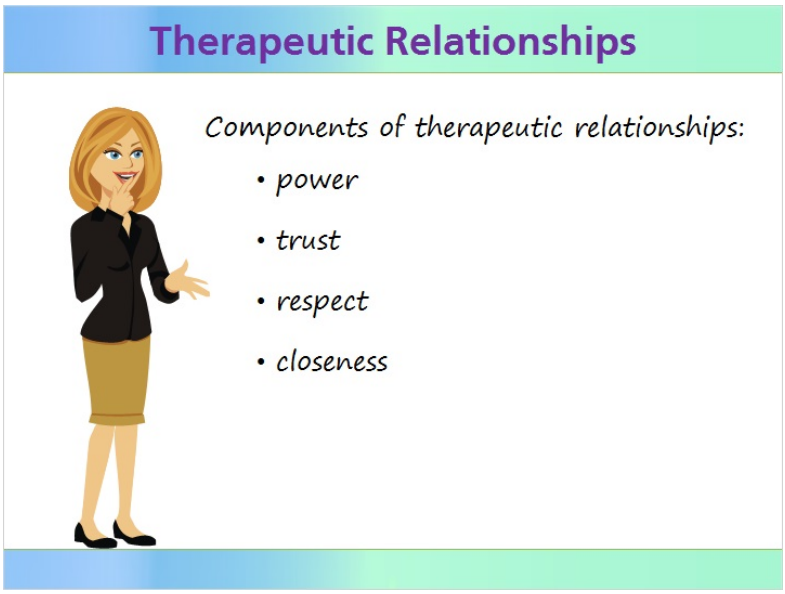
JILL: Hi … I'm Jill and with me is my colleague Carlos.
Welcome to Module 3 of the Patient Relations Course. This module is about professional boundaries and therapeutic relationships between SLPs, audiologists and their patients.

CARLOS: Hi Jill. I see that the topics that we will be discussing include: the nature of therapeutic relationships between an SLP or audiologist and their patient; what professional boundaries are, and the importance of avoiding boundary crossings. We are going to discuss trauma-informed practice. This practice approach is designed for working with patients or survivors who have psychological and emotional issues due to past sexual abuse or other traumatic events. As part of trauma-informed practice, we will give some important suggestions on how SLPs and audiologists should respond if a patient discloses that they have personally experienced sexual abuse. And finally, we will provide some guidelines for physical touching.

JILL: We have a lot of information to cover, so let's get started.

CARLOS: Okay.

3.3 Therapeutic relationships



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Narration

JILL: SLPs and audiologists need to recognize the difference between therapeutic relationships and non-professional relationships. A therapeutic relationship is one that places the patients and their needs first and foremost. SLPs and audiologists must not exploit the professional relationship for their personal gain or satisfaction.

CARLOS: Boundaries for professional or therapeutic relationships involve four key components: power, trust, respect and closeness. Let's examine each of these.

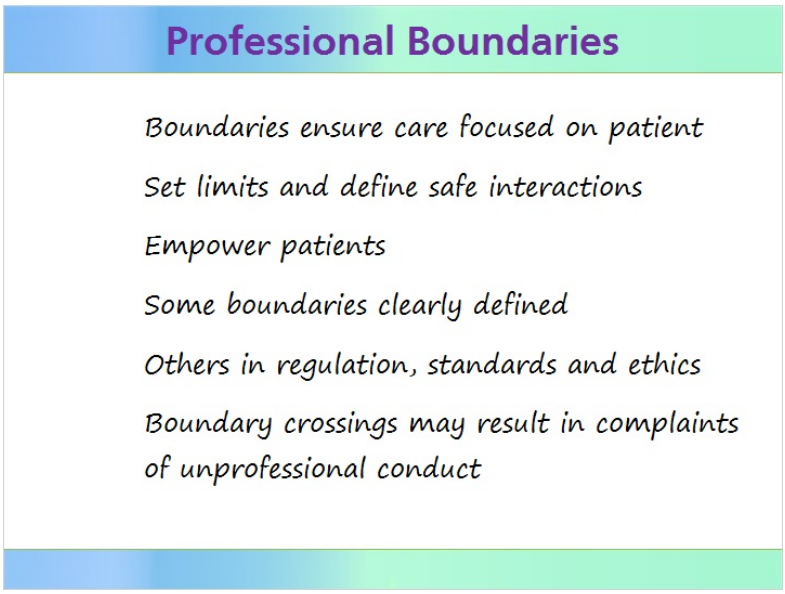
JILL: Every therapeutic relationship has an imbalance of power. Because of this power imbalance, a patient cannot provide unbiased and free consent. The SLP or audiologist holds the balance of power in their position as the health care provider, the keeper of specific knowledge and training, and the patient's dependence on them to provide the care needed. SLPs and audiologists also have access to personal information about the patient and have influence over the treatment provided.

CARLOS: Patients are vulnerable and they trust that their regulated SLP or audiologist has the knowledge, skills, abilities and professional judgment to provide the services that they need. The SLP or audiologist, in turn, has a responsibility to work in the patient's best interests. Trust that is lost through poor quality, exploitive or harmful care is not easily re-established.

JILL: SLPs and audiologists must treat all patients with respect and dignity regardless of gender, race, or other unique characteristics. Regulated members must respect the patient's right to be involved in their own care and recognize factors affecting patient decisions. Patients must have all the necessary information to give informed consent for health care services; and they may withdraw their consent at any time.

CARLOS: Therapeutic relationships can place individuals in positions requiring close physical proximity, the sharing of emotional or sensitive personal information, and psychological disclosure. This closeness is not normally experienced in everyday casual encounters. SLPs and audiologists MUST establish boundaries to ensure this closeness is not misinterpreted or misused.

3.4 Professional boundaries



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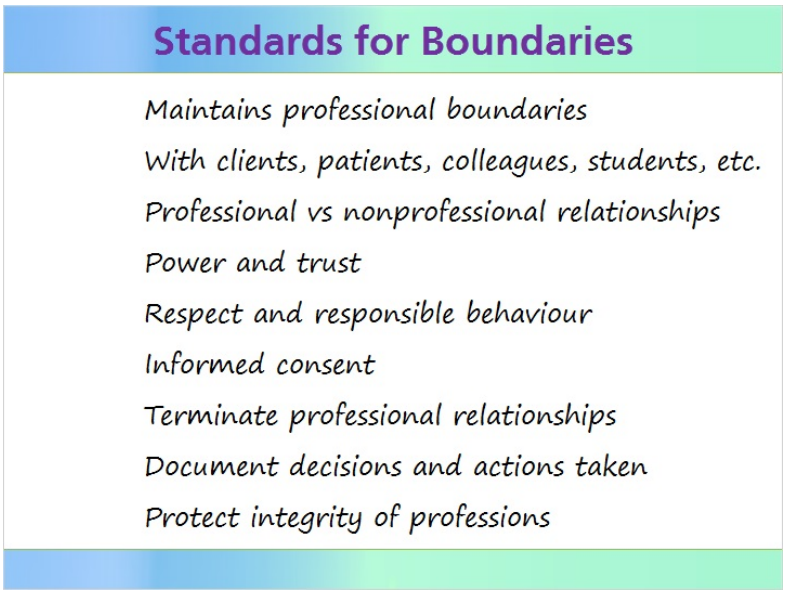
Narration

JILL: Professional boundaries are necessary to ensure the full benefit of care is focused on the patient. Professional boundaries set limits and clearly define the safe, therapeutic connection between the SLP, audiologist and their patients. Well-defined and respected boundaries empower patients to feel a sense of participation and control in their own health care.

CARLOS: Some boundaries are clearly established in legislation, while other boundaries are defined by the regulatory bodies through regulation, practice standards and code of ethics.

JILL: Professional boundaries apply to more than just patients. Regulated members' interactions with their patients, clients, colleagues, students and others that lead to abuse, harassment, romantic or sexual relationships are never appropriate! Flagrant boundary crossings will be investigated by the College and are subject to unprofessional conduct and/or other penalties prescribed by the *HPA*.

3.5 Standards



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Narration

JILL: Professional boundaries for regulated ASCLPA members are defined in the College's *Standards of Practice* 3.3 and 5.3. *Standard 3.3 – Professional Boundaries*, states that a regulated member of ACSLPA acts with integrity and maintains appropriate professional boundaries with clients, patients, professional colleagues, students and others at all times.

CARLOS: *Standard 5.3 – Managing Professional Boundaries*, states that a regulated member recognizes when professional boundaries may be compromised by feelings, conduct, behaviour or remarks of a sexual nature, regardless of who initiates it.

JILL: To comply with these standards, the ACSLPA regulated member must do several things. The first is to demonstrate understanding of the distinction between professional and nonprofessional relationships, the elements of power and trust, and the situations when professional boundaries could be compromised, such as treating family members and friends.

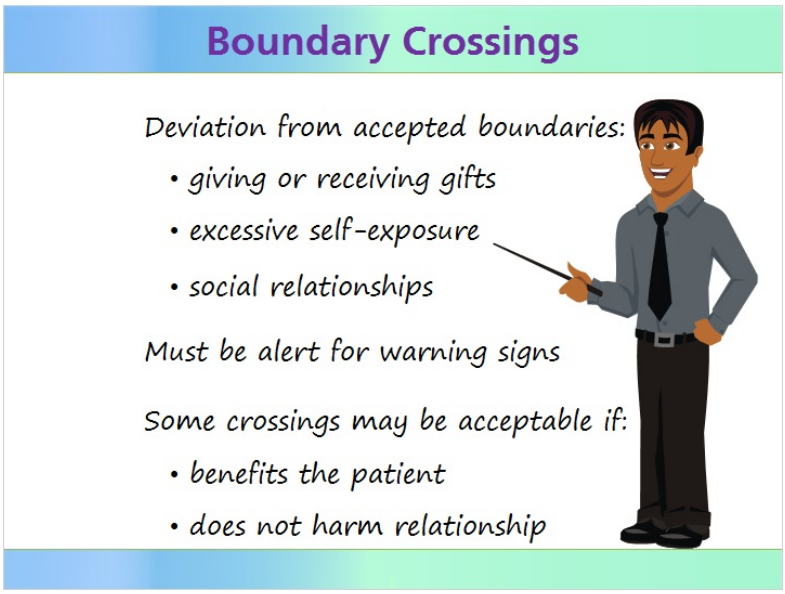
CARLOS: The regulated member must demonstrate respect and responsible behaviour to patients, clients and colleagues at all times, including avoiding sexually suggestive comments or actions or the expression of opinions or remarks that could violate professional boundaries.

JILL: The regulated member must exercise additional care to ensure that informed consent is obtained for procedures that patients could misinterpret, such as touching or physical closeness.

CARLOS: The regulated member must terminate a professional relationship if boundaries cannot be established or maintained, transferring care as necessary. If this happens, it is important for the SLP or audiologist fully document the decisions made and the actions taken to ensure the best interests of the patient.

JILL: And finally, the regulated member must protect the integrity of his/her profession by being responsible and accountable for his/her actions at all times including personal interactions and the use of social media.

3.6 Boundary crossings



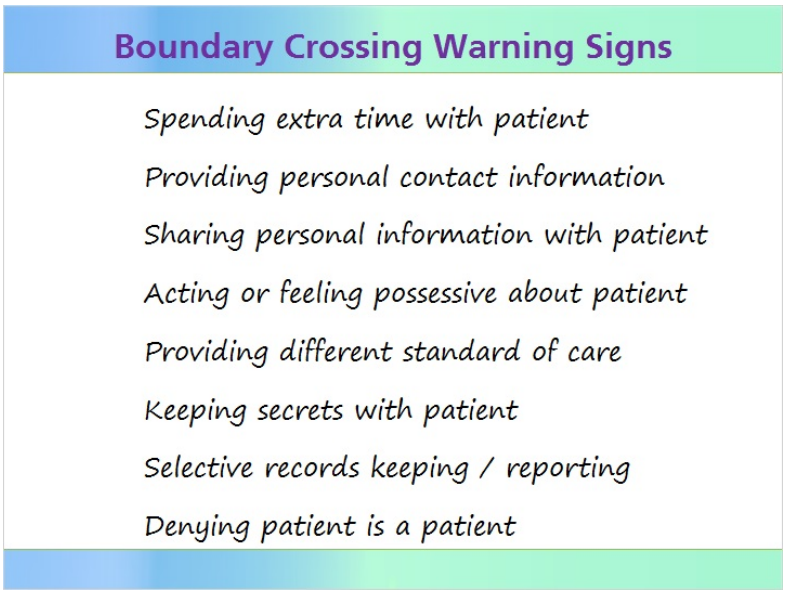
Narration

CARLOS: Boundary crossings occur when the behaviour of the SLP or audiologist deviates from the accepted boundaries of a therapeutic relationship. Normally, behaviours such as giving or receiving gifts, self-disclosure and social relationships are not part of the speech-pathology or audiology practice. These are considered to be generally inappropriate behaviours in a therapeutic relationship between a regulated member and their patient.

JILL: SLPs and audiologists must constantly be alert for behaviours that fall outside of the norm and monitor their professional relationships for warning signs of boundary crossings.

There may occasionally be circumstances when behaviour typically considered inappropriate in a therapeutic relationship may be acceptable. For example, the SLP or audiologist disclosing similar experiences may reassure and calm the patient. Likewise, a small token of thanks from a patient is not likely to negatively impact the relationship or create an expectation of special treatment in the future and is probably acceptable.

3.7 Warning signs



Narration

JILL: There are warning signs that an SLP or audiologist has crossed, or may be about to cross a professional boundary. One warning sign is when a member is spending extra time with a patient beyond the scheduled appointments or normal office hours.

CARLOS: Another warning sign is when the SLP or audiologist provides the patient with their personal contact information.

JILL: Sharing personal information generally with the patient is another sign of a possible boundary crossing.

CARLOS: Another warning sign is acting or feeling possessive about a patient.

JILL: Providing a different standard of care for a particular patient compared to other patients is a boundary crossing warning sign.

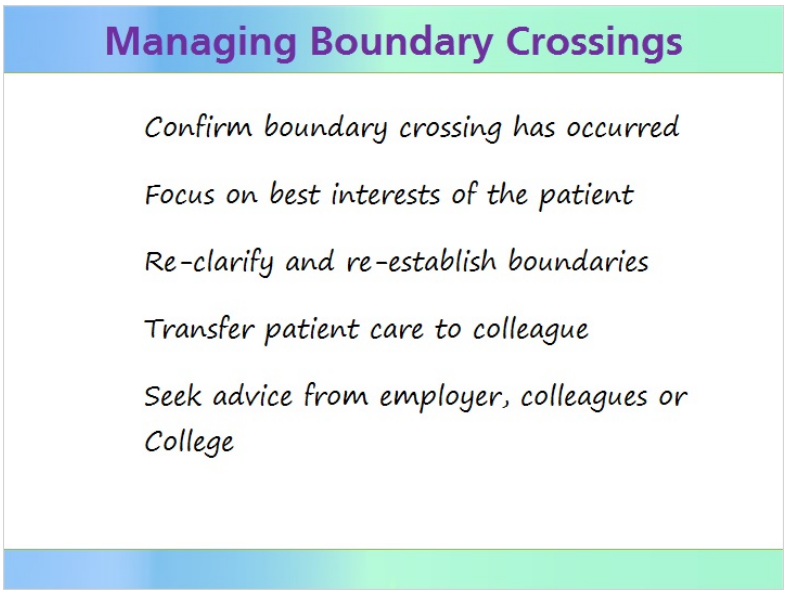
CARLOS: Keeping secrets with a patient is a warning sign.

JILL: An SLP or audiologist who is selective rather than complete in record keeping or reporting may be crossing a professional boundary.

CARLOS: And the last example of a possible boundary crossing warning sign is when the regulated member denies that the patient is a patient.

JILL: These are just some examples of warning signs of professional boundary crossings. There is more detailed information in the College's guideline and in the checklist in module 5 that can be used to assess whether a boundary has been crossed.

3.8 Managing crossings



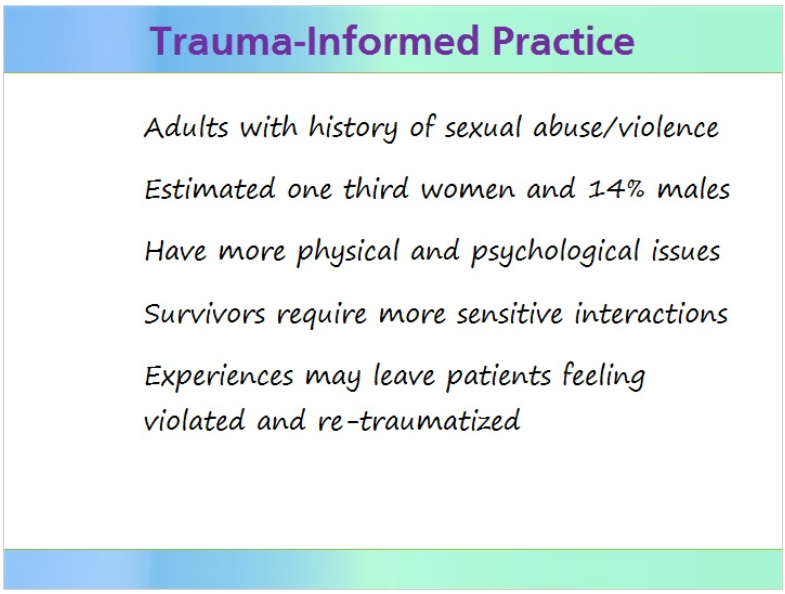
Narration

JILL: Let's talk about what an SLP or audiologist should do if they have deliberately or inadvertently crossed a professional boundary with a patient. The first thing to do is to objectively as possible, confirm that in fact they did cross the boundary. This can be done by focusing clearly on what is best for the patient.

CARLOS: If a boundary has been crossed, it is up to the professional to re-clarify and re-establish the boundaries. If this is not possible, the member may have to discontinue the patient / practitioner relationship by having a colleague provide the required health care services for the patient. As we mentioned before, decisions and actions taken to facilitate the transfer of a patient to another regulated health professional should be documented.

JILL: Speaking with a supervisor, trusted colleague or the College may help you to determine the best strategy to maintain boundaries and ensure the patient's welfare remains first and foremost.

3.9 Trauma-informed practice

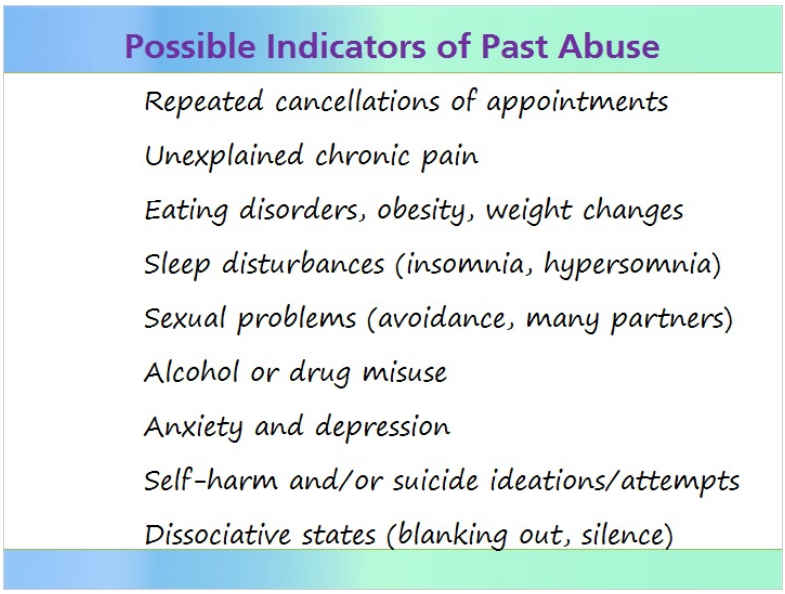


Narration

JILL: Trauma-informed practice enables health care practitioners to practice in a manner that is appropriate to the needs of survivors of sexual abuse and other types of interpersonal violence. In Canada, it is estimated that one third of women and 14 percent of men are survivors. This population that has experienced sexual, physical and emotional abuse, is associated with a greater risk for a variety of physical and psychological health problems.

CARLOS: Examinations and procedures that are considered routine or innocuous can be distressing for survivors because they can cause the patient to relive the original trauma. Exclusive focus on the body, lack of control, invasion of personal boundaries, exposure, vulnerability, pain and sense of powerlessness are common experiences in the health care environment. These experiences may be extremely difficult for survivors because it leaves them feeling violated and traumatized all over again.

3.10 Abuse indicators



Narration

JILL: There are certain indicators that should alert the SLP and audiologist that a patient may have experienced sexual abuse. The first indicator is that many people who have experienced sexual abuse repeatedly cancel their appointments because they find them so stressful.

CARLOS: Other common indicators of past abuse may include: unexplained chronic pain; eating disorders resulting in obesity or weight changes; and sleep disturbances such as insomnia or hypersomnia.

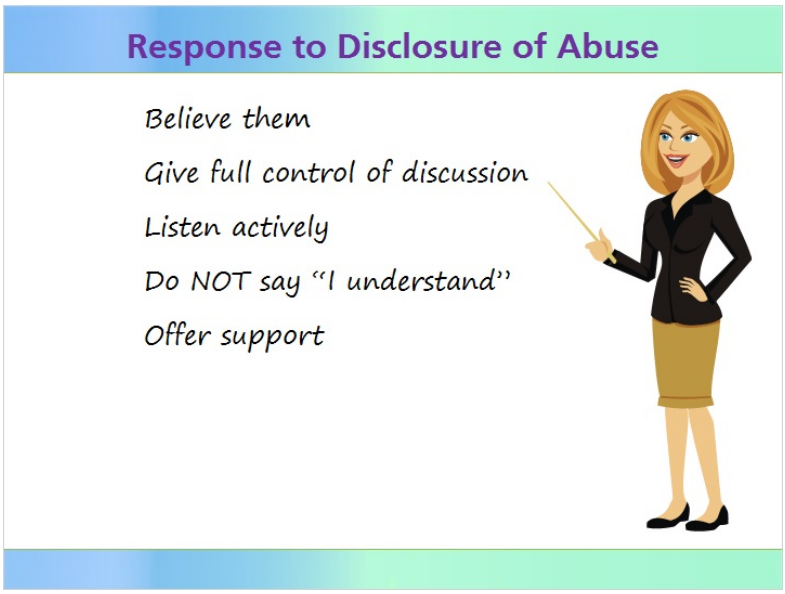
JILL: Sexual abuse indicators may include total avoidance of sexual relationships to the other extreme of having many partners. Alcohol and drug misuse, anxiety and depression, and self-harm or suicide ideation and attempts may be other symptoms. Another prevalent symptom is the patient having dissociative states such as blanking out or prolonged silence.

CARLOS: SLPs and audiologists should NOT directly ask a patient if they have a past history of abuse and associated trauma. However, a regulated member should carefully monitor each patient's conversation and body language. If you detect anything unusual, you should ask the patient if they have any issues or any concerns, or whether they are uncomfortable, either physically or emotionally, about the appointment or anything you are saying or doing.

JILL: To ensure the best patient experience, we recommend that SLPs and audiologist should routinely use trauma-informed practice strategies for ALL of their patients.

CARLOS: Yes, I agree. Using this approach will benefit all patients, not just survivors!

3.11 Response to disclosure



Narration

CARLOS: Jill, what should an SLP or audiologist be prepared to say and do if a patient discloses to them that they have experienced sexual abuse or sexual misconduct in the past?

JILL: That is a really good, and very important, question. Here are the guidelines that were provided to us by experienced sexual assault therapists. First, believe what the person who has experienced abuse is telling you. False reports of sexual abuse or misconduct are extremely rare.

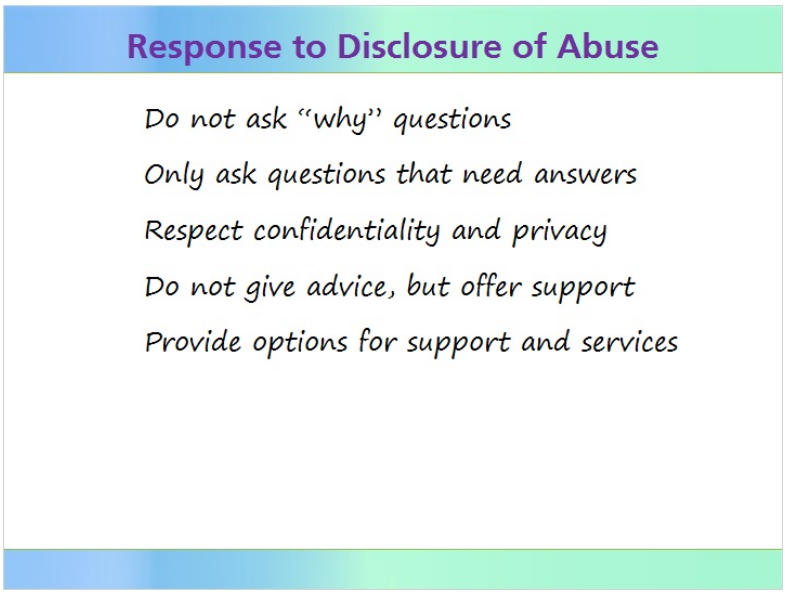
CARLOS: You should give the person who is disclosing the information full control of the discussion. Allow them to take all the time they need. Understand that full disclosures are rare. Do NOT push for more information than they are ready or willing to share.

JILL: Listen actively. Re-state what you are hearing using similar language as the person who has experienced abuse to show that you are listening and hearing them. Do not judge. Do not pry. Accept what they are telling you.

CARLOS: Do NOT say, "I understand". This diverts the attention away from the person disclosing and focuses the attention on you. You are not the one in need of attention right now.

JILL: Offer support. Some things that you can say are: "This is not your fault. I believe you. Thank you for telling me. I am here for you. How can I help?"

3.12 Response to disclosure



Narration

CARLOS: Do not ask "why" questions. These can sound accusatory. Do not ask for details of the incident. You do not need the information and the person who experienced abuse may not be ready to talk about it. Do not ask if they said "no" or tried to get away. Reactions to stress or trauma include fight, flight and freeze. The most common response in sexual abuse is "freeze" which includes the inability to speak or fight back.

JILL: Only ask questions for which you require an answer. You are not investigating and you are not counselling. You are only offering support. Your curiosity has no place in this process!

CARLOS: Respect the patient's confidentiality and privacy.

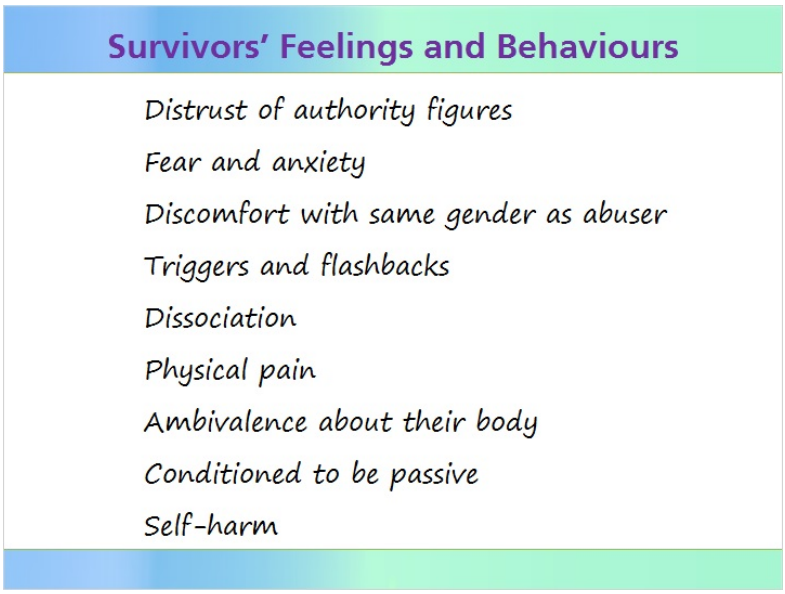
JILL: Do not give advice! Support is not advice. Professional services are available from a variety of qualified sources for advice and follow-up care.

CARLOS: Ask if the person who has experienced abuse would like you to provide them with some options for support and services available to help them. The *Patient Referral Guide* and app in Module 5 can be used to find the most appropriate resources.

JILL: It is important to stress that SLPs and audiologists should know and practice these appropriate responses. Otherwise, they risk re-traumatizing the patient.

CARLOS: Yes, I agree.

3.13 Survivors' feelings



Narration

JILL: Let's now examine some of the underlying feelings and behaviours of survivors. This will help SLPs and audiologists better understand and adjust to their patients' fears and concerns while providing trauma-informed service.

CARLOS: Survivors have experienced violation at the hands of an authority figure. Although this distrust originates in the past and should not be taken personally, survivors constantly scrutinize health care practitioners for evidence that they are taking active and ongoing steps to demonstrate their trustworthiness.

JILL: Many survivors experience tremendous fear and anxiety during health care encounters. The experiences of waiting, being in close physical contact with authority figures, and not knowing what is to come, all resonate with past abuse.

CARLOS: For some survivors, the gender of a person in a position of authority is a power "trigger" that can leave them feeling vulnerable and unsafe. This strong reaction prevents some survivors from seeking care from practitioners who are the same gender as their abuser.

JILL: Examination or treatments may "trigger" or precipitate flashbacks, a specific memory or overwhelming emotions such as fear, anxiety, terror, grief or anger. A flashback is the experience of reliving something that happened in the past and usually involves intense emotions.

CARLOS: Survivors may experience dissociation during interactions with health care providers. Dissociation ranges from daydreaming and lapses of memory to pathological failure to integrate thoughts, feelings and actions.

JILL: For some survivors, the experience of acute and/or chronic physical pain may be associated with past abuse. The association can manifest itself in various ways – some individuals have learned to ignore or dissociate from the pain, while others are hypersensitive to it.

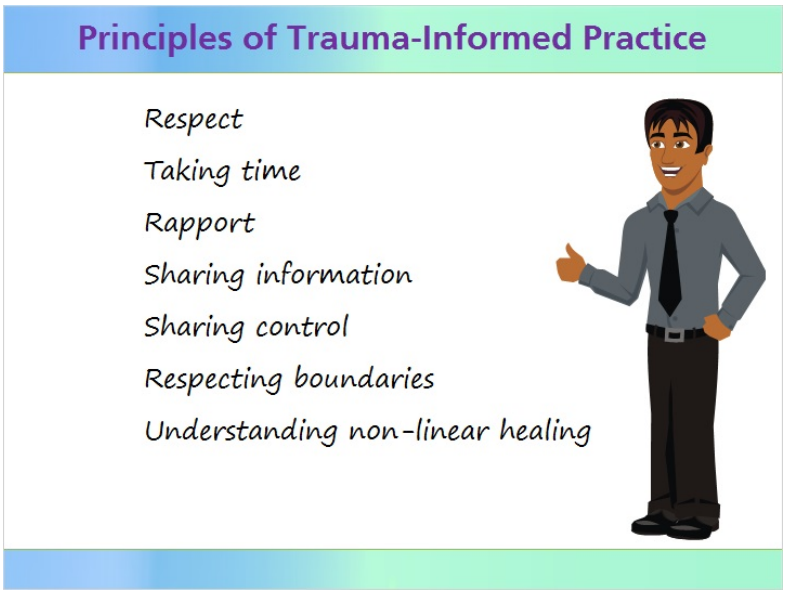
CARLOS: Many survivors feel hate, shame, and guilt about their bodies. This shame and guilt may lead some survivors to feel ambivalent about and disconnected from their bodies. This ambivalence can affect description of symptoms, response to treatment, and ability to self-monitor effects of an intervention or medication.

JILL: Abuse can teach individuals to avoid speaking up or questioning authority figures. Survivors may have difficulty expressing their needs to a health care practitioner who is perceived as an authority figure.

CARLOS: Self-harm such as scratching, cutting, or burning of skin is a way some survivors attempt to cope with long-term feelings of distress. Self-harm may take more subtle forms as well, such as ignoring health teachings or recommendations for treatment or symptom management.

JILL: Now that we understand the feelings and behaviours of survivors, we are in a better position to know how to use trauma-informed practice when providing care.

3.14 Trauma-informed principles



Narration

JILL: Here are seven principles of trauma-informed practice. We strongly recommend that these principles be applied to ALL patients.

The first principle is *Respect*. Respect means acknowledging the inherent value of each individual, upholding basic human rights with conviction and compassion, and suspending critical judgement. Because abuse undermines an individual's personal boundaries and autonomy, survivors often feel diminished as human beings and may be sensitive to any hint of disrespect.

CARLOS: The second principle is *Taking Time*. Being rushed leaves many patients feeling depersonalized and devalued. For some, being rushed or treated like an object diminishes their sense of safety and undermines any care that follows. It is important to remember that feeling genuinely heard and therefore valued, is healing in itself. In some cases, this is the most effective intervention a practitioner can offer.

JILL: The third principle is *Rapport*. While rapport is essential to every therapeutic relationship, it is an absolute necessity to facilitate safety for survivors. Practitioners who are warm and compassionate facilitate good rapport and subsequent feelings of safety. Good rapport not only increases an individual's sense of safety, but also facilitates clear communication and cooperation.

CARLOS: The fourth principle is *Sharing Information*. While knowing what to expect decreases anxiety for most people, it is particularly important for survivors. Being told what to expect on an ongoing basis helps allay survivor's fear and anxiety, and often prevents them from being triggered by unanticipated events. Practitioners must also seek ongoing feedback about the survivor's

reactions to the exam, treatment or intervention throughout every encounter and prior to the next encounter.

JILL: The fifth principle is *Sharing Control*. A central aspect of sexual victimization is the loss of control over one's body. Therefore, having a sense of personal control in interactions with health care providers who are more powerful is crucial to establishing and maintaining safety. Sharing control of what happens in the health care interaction enables patients to be active participants in their own care, rather than passive recipients of treatment.

CARLOS: The sixth principle is *Respecting Boundaries*. Survivors say that practitioners' questions and actions, when initiated either without explanation or without permission leave them feeling violated. By demonstrating respect for, and sensitivity to, personal boundaries, practitioners model healthy boundaries and reinforce patients' worth and right to personal autonomy.

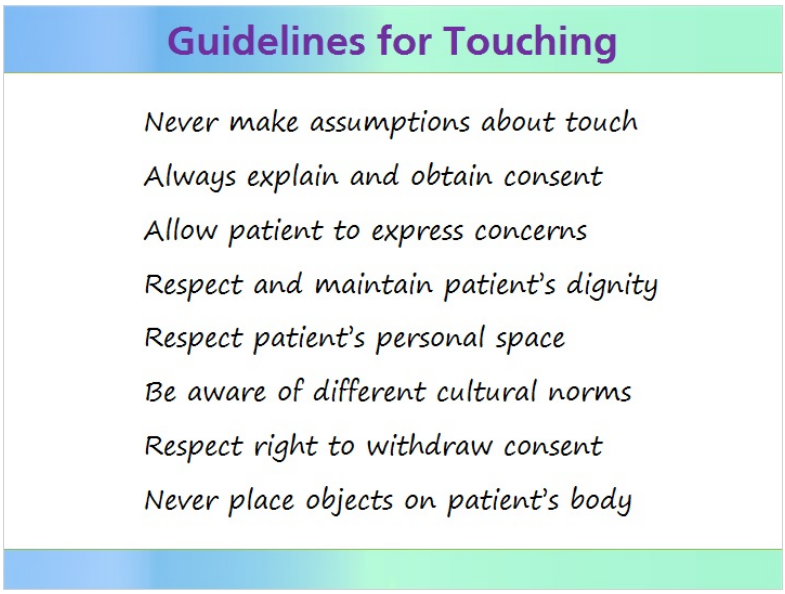
JILL: The seventh principle is *Understanding Non-linear Healing*. Survivors mention repeatedly that healing and recovery from abuse is not a linear process. The degree to which a survivor is able to tolerate or participate in treatment may vary from one health care encounter to the next. This means that practitioners must check in with their patients throughout each encounter and adjust the behavior according.

CARLOS: Wow – that is a lot of information!

JILL: Yes it is. BUT it is important information for every health professional to know. Consciously applying these principles can not only enhance the therapeutic relationship with survivors, but also assist the practitioner to avoid re-traumatizing the patient. Many survivors have said that interactions with health care providers have left them feeling violated and re-traumatized.

CARLOS: And by applying these trauma-informed principles to ALL patients, the risk of re-traumatizing survivors is greatly reduced. And an added benefit is that all patients will benefit from an enhanced health care experience.

3.15 Touching guidelines



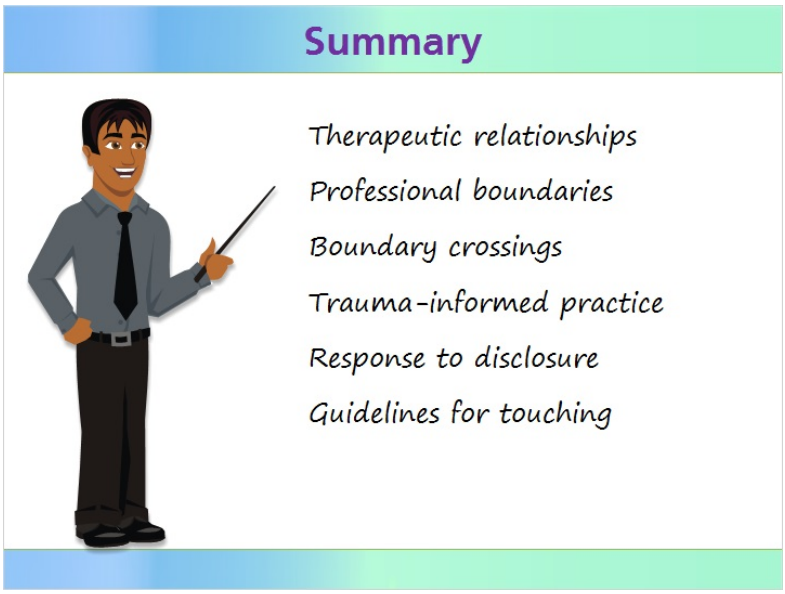
Narration

JILL: Here are some recommended guidelines for SLPs and audiologists regarding the touching of their patients. Never make any assumptions about the patient's acceptance or tolerance for being touched. For survivors, no touch is routine. Always explain what and why you want to touch, and obtain prior consent.

CARLOS: Be sensitive to the intent and nature of all touch, and discuss the patient's reactions to different types of touch. It is important to allow and encourage the patient to express concerns and feelings regarding different types of touching in assessments and monitoring of treatments.

JILL: Always demonstrate respect for the patient; maintain the patient's dignity, and respect the patient's personal space. Be aware of different cultural norms related to touching. Respect the patient's right to withdraw consent at any time. And, unless absolutely necessary, do not place objects on the patient's body.

3.16 Summary



Narration

JILL: Well, this brings us to the end of Module 3. Carlos, do you mind doing a short summary of what we covered?

CARLOS: Sure, I would be happy to! We began this presentation by defining therapeutic relationships and describing the four important components of these relationships: power, trust, respect and closeness. We then explained professional boundaries and their role and importance for safe therapeutic relationships between SLPs, audiologists and their patients.

We examined boundary crossings – behaviours that occurs when a regulated professional deviates from accepted boundaries within a therapeutic relationship. Some warning signs of boundary crossings were presented. We explained what must be done when an SLP or audiologist crosses a boundary.

Trauma-informed practice was discussed next. This approach should be employed with all patients, not only those who are survivors of sexual abuse and other types of interpersonal violence. Possible indicators of past abuse were described. Specific suggestions were given as to how an SLP or audiologist should respond if a patient discloses to them that they were sexually abused. We explored survivors' feelings and behaviours that often result from their traumatic past experiences. Seven principles of trauma-informed practice were described to give ACSLPA members some specific strategies that they could employ with all of their patients. Our last topic was on guidelines for physical touching. Did I miss anything?

JILL: No, that summarizes this Unit. Thanks for doing that. I'm Jill, here with Carlos, saying goodbye for now. We will see you again soon.

CARLOS: Bye.

3.17 The End

Menu

Narration

No narration, only theme music.