Safeguarding vulnerable adults whilst promoting social inclusion: negotiating professional boundaries.

By Peter Bates, National Development Team for Inclusion

Introduction

Current attempts to safeguard vulnerable adults have not, in general, been 'exclusion-proofed' and so inhibit efforts to promote inclusive lifestyles, thereby paradoxically increasing vulnerability and exclusion. There is a compelling need to explore this field in order to protect people and ensure that efforts to support citizenship are not adversely affected by staff fears of accusation. This paper examines some of the issues that need to be taken into account when establishing professional boundaries in the context of inclusion work.

#1: Have your policies on professional boundaries and safeguarding vulnerable adults been reviewed by people who are experienced and knowledgeable about social inclusion work?

We recognise that the traditional mental health service has been characterised by inequalities in power and a tendency to exclude, and so deliberate action is needed to overcome these problems and place inclusion and self-directed recovery at the centre. Both policy and practice will need to recognise and respond to the range of factors involved, support the autonomy, inclusion and recovery of the person, protect from abuse and promote reflective practice and continuous development of both individuals and services.

#2: What core values drive your policy on professional boundaries?

This paper considers three questions:

- the practitioner's question - what is the right thing to do?
- the policymaker's question - how do I reconcile these contradictory goals into text? and
- the employee's question - how do I avoid punishment?

Most of this document was written in 2009. Small amendments have been made since, most recently on 18 June 2018.

People using services are excluded

Compared to the general public, people using mental health services are less likely to have qualifications, a job, their own home, long-term relationships or friendships, or belong to clubs or associations. Importantly, such exclusion increases risk (DH 2008), so promoting inclusion is a risk-reducing intervention (EHRC 2009, p29), and government has voiced its support for this endeavour: 'if people are less isolated and have support to participate in their community, this may provide some protection from abuse' (CSCI 2008, p13).

The UK Government policy aims to reduce exclusion (SEU 2004). Vigorously promoting personalisation and individualised funding arrangements instead of the direct provision of services will generally lead to empowerment and support inclusive lifestyles, but we expect it to add further complexity to discussions about professional boundaries. Furthermore, increasing participation in mainstream settings moves people away from the oversight of health and social care.

Finally, building a cohesive society in which bonding, bridging and linking relationships generates social capital, increases the likelihood that people using health and social care services will encounter other citizens (including staff who support them) in other settings and relationships.

> #3: Are people working to promote social inclusion sufficiently aware of their responsibilities to safeguard vulnerable people?

People using services are vulnerable

People with mental health issues are more likely than the general public to experience discrimination, reduced opportunity and even be victims of crime (Thornicroft 2006). An array of Government policy initiatives are designed to safeguard vulnerable adults (DH 2008) through the personalisation of services. However, boundaries thinking has not caught up with personalisation. Doel et al (2009, section 6.4) reviewed policy documents from professional bodies and service providers and conclude:

> *It is curious that they are entirely silent in respect of the ambiguities surrounding service users' 'self-directed support.' It should be noted, however, that human resources matters abound in circumstances of service users employing their own staff. The employees to whom the documents are addressed are required to promote personalisation to vulnerable adults and their family caregivers (there were 152,000 Personal Assistants employed by Direct Payments Recipients in 2007-08 in England). Professional boundary violations require effective and decisive action, including preventive measures and training. There is no requirement for Personal*

Assistants to be trained, CRB checks are not compulsory and their Terms and Conditions are determined by the Direct Payments Recipients.

Large and diverse social networks improve quality of life for most people and create mutual informal advocacy networks that spot and challenge abuse. As CSCI has noted, ‘isolated people with few or no visitors are at greater risk.’ (CSCI 2008 p36) and it has been suggested that safeguarding is a responsibility that the community shares with professionals (DH 2008). However, we need to acknowledge that social exclusion and the blurring of professional boundaries are only two items in a long list of the determinants of vulnerability to abuse.

Some people are not in a position to assess where the boundary should be, or (more often) are not able to insist that the boundary is kept. So powerful people are then able to create, cross or violate the boundary, and vulnerable people are sometimes unable to define when ‘crossing’ becomes ‘violation’.

This may be particularly the case for people using services in respect of Article 8 of the Human Rights Act 1998 – the right to privacy. In dentistry, it is fairly clear which subjects fall into the remit of the assessment and asking about other topics would be an infringement of the right to privacy. In mental healthcare, it is more difficult to find the line. The Act permits legitimate, proportionate inquiries that assist in diagnosis and treatment and are necessary in a democratic society to protect health, morals or the safety and freedom of others. Intrusive nosiness, surveillance and arbitrary interference are outlawed and this is reinforced by Government advice (DCA 2006 para 3.70) that information should not be collected or used unless there is a very good reason and people have a right to know what is collected. Article 6 of the Act explicitly requires public bodies to act compatibly with people’s rights. It is interesting to note that none of the respondents to Doel et al’s inquiries (2009, section 5.4) mentioned human rights. Caselaw suggests that these decisions must be made on a person-by-person basis, rather than as a blanket decision.

For example, one mental health service has recently issued an instruction to all staff to report every off-duty contact with all service users to their line manager. Whilst this may be presented as a means of protecting staff from allegations of inappropriate conduct, the law guides us to ask:

- Is this a person-centred decision? The instruction to do this for everyone suggests not, and therefore the action may be judged as a breach of the service user’s right to privacy.
- Is this for the health and protection of the individual concerned? A few individuals may need such active surveillance in order to manage their mental

ill-health, but others would gain no health benefit or additional protection from this action at all. As such, it breaches government guidance to public bodies.

- Is it proportionate? Would a less intrusive approach achieve the same result? For many service users, their own ability to complain combined with access to other workers, independent advocacy and support from family and friends would form an adequate early warning system to alert the service to an abusive situation. Offering training to service users to help them recognise and report abuse by staff might be a less intrusive approach. The Human Rights Act insists on a 'very good reason' in terms of health gain and protection if the right to privacy is to be set aside.
- Does the person have a choice? Article 8 includes a right to develop one's own personality, create relationships with others, refuse medical treatment and see personal records kept by public authorities. Workers writing records of their off-duty contacts with a service user need to be able to explain to that person how making a record of the contact enhances the health and protection of that individual.

Safeguarding inclusive practice

The two policy strands of inclusion and safeguarding come together every day when health and social care staff find themselves supporting people in public places. In general it is the least qualified who are more frequently in these ambiguous situations, while highly qualified staff spend less time face to face with people and are more likely to be meeting people in formal interview rooms.

Providing subtle support on a one-to-one basis in public places demands tact and skill (Bates 2008), but few mental health or learning disability organisations that we have encountered have set out guidelines or created supervision or learning opportunities to assist staff in developing these skills.

#4: What guidance do you offer staff who work with people in public places?

More broadly, there are a large number of factors complicating the relationship between safety, inclusion and professional boundaries and the commonest response is bewilderment and inconsistency. Reamer (2003) reports on a US empirical study that found substantial disagreement amongst social workers concerning the appropriateness of developing friendships with service users, participating in social activities, serving on community

boards, disclosing one's home telephone number and discussing religious beliefs. A similar study has found similar variations amongst UK social care workers:

> *"In 2009 the General Social Care Council (GSCC) published Raising standards: Social work conduct in England 2003-2008. This constituted the GSCC's first report covering the work undertaken to uphold standards and protect people who use social care services. The GSCC's analysis revealed that a considerable proportion of conduct cases, some 40%, involved allegations of 'inappropriate relations'. (Doel et al 2009, section 1.1)*

It is hard to know the actual level of abuse. As the following two extracts from Doel et al (2009, section 4.1.i) put it:

> *A report of social work activity in England between 2003-08 (GSCC, 2008) recorded that allegations were received regarding less than 1% (n=503) of the registered workforce in 2007-08 and in 2006-08 only 0.04% (n=36) of the total workforce of social workers and students have appeared before a hearing. By far the largest category of complaint was poor professional practice (46%), and the pattern was for multiple and related transgressions. The most common breach is 'behave in a way, in work or outside work, which would call into question your suitability to work in social care services'. A considerable proportion of complaints that end as conduct cases (40%) involve allegations of inappropriate relations."*
>
> *In 1993 the NASW Center for Policy and Practice reviewed a random sample of 300 cases drawn from all complaints to NASW for the period 1982 to 1992. The researchers found that, of 226 alleged violations, 72 were substantiated through hearings. They found that 29% of those who breached the Code of Ethics did so by violating the prohibition against sexual activity with clients. This was followed by conflicts of interest (17% percent of violations); precipitous withdrawal of services (17%); exploitation of professional relationships for personal gain (16%); dishonesty, fraud, and deceit (14%); succumbing to pressures that affect impartiality (violated by 13%); exploitation of client (13%); and failure to terminate or transfer a case appropriately (12%). Findings involving other tenets of the Code occurred in fewer than 12% of the cases reviewed.*

Such confusion does not

- result in consistent behaviour when several staff who may have differing viewpoints support the same person.

- help a worker who is pondering on the right course of action, since asking colleagues will probably yield no more than a range of personal viewpoints.
- keep people safe. Following the controversial removal of children into public care on the island of Orkney in 1991, one witness contended that '*it is highly desirable that they (social workers) should both know the community, its character, traditions and customs, and be known by those whom they are there to serve. The trust and confidence which each should have in the other cannot be effectively secured if the social worker appears as a remote occasional visitor who does not in any sense belong to the area*.' (Clyde 1992, p340)

#5: What core ideas underpin your policy?

Drawing on models

Metaphors and images are easy and memorable ways of gaining an understanding but they are also fraught with danger. Even terms that have the appearance of simplicity arrive loaded with assumptions and pre-suppositions that can block a thorough understanding and inhibit practice. For example, the image of a boundary may suggest a mechanistic, inanimate world rather than one comprised of fluid relationships and flexible membranes.

Perhaps we will need to be informed by other models, such as systems or complexity theory, by ideas of individuals and organisations as complex, adaptive organisms with multiple identities rather than as simple machines that follow the rules of mechanics. Relationships between individuals and their organisation and between one group and another will most likely follow complex patterns. Thus it follows that achieving accountability and integrity in such an environment is unlikely to be accomplished by publishing simple regulations (such as Bullivant et al 2008).

The focus might shift from the person to the worker or even burden the person with concerns for the worker's wellbeing (reciprocal exchanges of care perhaps belong in the informal network of relationships enjoyed by the person in their chosen community rather than the therapeutic relationship).

Several of the pioneers of psychotherapy, including Freud and Klein, have engaged in dual relationships. Even in psychotherapy, the form of the regulation depends on the modality of treatment. For example, psychotherapy that is delivered within a small group, such as the group-analytic approach, begins by forming a new group from people who are initially strangers to one another. An early part of the

negotiation within the group includes the recognition that there may well be contact between members outside the group, or that the therapist may encounter one group member elsewhere – and sets the expectation that all such encounters must be disclosed and their emotional significance reflected on within the group itself.

This, however, is something of an exception to the general rule that most talking therapy demands that we operate in a sterile, neutral environment (Lazarus & Zur 2002). As Freud and Krug (2002) suggest, 'social work's adoption of the psychoanalytic constraints of anonymity, neutrality and abstinence has detoured the profession from its original double focus on individuals and their society.' Oddly, while social care is taking up these values, they have been repudiated in many psychoanalytic circles.

Perfectly good regulations from the world of psychotherapy may be quite unsuitable for other settings. However, in the absence of a clearly articulated case for taking a different position, it appears that the most cautious path has been adopted, thereby applying rules from the psychotherapy room to all other relationships. This may be driven by the power differential that remains between the client and the staff member irrespective of professional affiliation.

Models of community

Reciprocity and linkages (through which my friends might become your friends) are perhaps the defining characteristics of community in that one relationship may lead to the development of another in a transitive way. He relates to me, and I to her, and in time he may come to relate to her. Such linkages enable communities to move information about and share responsibility for meeting needs and keeping one another safe.

Small rural communities commonly have many multi-stranded relationships that contrast with large, urban settings with high mobility, characterised by more single-stranded relationships and networks that bring people together on the basis of that one strand. As urbanisation and mobility increases, society at large is becoming progressively less familiar with and competent to manage multi-strand relationships. This is perhaps also linked with an increase in functional and commodified relationships in which people interact with one another over a single purpose or shared interest, rather than putting their 'whole self' into the interaction. Indeed, some views of professionalism itself is that it is necessarily an impersonal, technical intervention by a stranger so that any attempt to make the encounter personal would by definition make it 'unprofessional'.

As Doel et al (2009, section 4.1.iv) have it:

> *"The vocabulary used to discuss professional boundaries frequently puts distance between service users and professionals, almost as though service users are regarded as a different 'caste'. In these circumstances the boundaries seem less designed to uphold the proper consideration of power differentials, etc. and more to deny people who happen to use services certain rights, privacies and possibilities. Dietz and Thompson (2004) contrast a patriarchal 'distance' model of social worker-client relationships and a feminist 'relational' model; they view the drive to proceduralise social worker-service user relationships as a strengthening of the patriarchal model. The difficulty in moving between 'castes' is illustrated by the problems that workers and agencies have in deciding when and in what circumstances a person becomes a 'former' client or service user" (Mattison et al, 2002).*

This is in contrast with the user-focused care and asymmetric (dead-end) nature of the therapy relationship where my clients will not make friends with my friends. Denying the opportunity proves the relationship I have with him as a service user is compartmentalised and intransitive – it never leads to his relationship with others of my personal circle.

Different cultures, subcultures and communities will have different cultural norms, as may women and men, and so workers need to be effective at cross-cultural dialogue rather than retreating behind rigid assertions (Bates and Rooms 2008).

Learning disability services have seen some very clear shifts in the cultural understanding of the worker/person relationship, moving from nurse/patient in the era when learning disability was seen as an illness, through teacher/student to carer/vulnerable or even friend/friend. As one anonymous correspondent put it on the Choice Forum (8 April 2009)

> *"What we all want is to be supported by and to engage with real people who care about us. Real friends challenge and encourage. They talk to us with respect and in an ordinary way. For a support worker to behave as a friend in this sense is exactly what we want. Years ago we may have thought in terms of a nurse-person relationship, then a teacher - person relationship. Friend is much better. The professionalism comes in terms of treating all people the same. In my working life I would count many of the people I have worked with as friends."*

The community and the service may have competing understandings of: distress and its causes, the individual and the community, motivation and responsibility, privacy and disclosure. Each participant will also have a different view of the acceptable way

to conduct a relationship. Pretending that this complex area can be managed via a few simple prohibitions, as some policies appear to do, stands in stark contrast with our society's love of diversity and its suspicion of fundamentalism. The proliferation of regulation that has occurred in the last two decades is perhaps a consequence of the decline in our society's trust of professionals who traditionally would have been accorded considerable autonomy. The process is self-reinforcing, since the tightening of control leads to an increase in disciplinary actions which reduces the community's trust in the professions and leads to a further increase in attempts to control by regulation.

A particular area where perceptions vary is the importance of personal integrity and consistency between a professional's work and personal life. Dressing up for a social event, behaving in a uninhibited manner, getting drunk or even adopting distinctive childrearing practices may be subject to scrutiny by the community and influence the service user's view of the worker and the effectiveness of interventions. However, maintaining an aloof detachment may obstruct the development of trust.

Models of friendship

Another term we need to unpack is 'friendship'. Jill Kemp (2009) writes:

> *'without the friendship of staff, most clients had no friendships at all. Surely one of our roles as quality supporters includes alleviating feelings of loneliness. ... it is often the relationships between staff and clients that run deeper, are more trustworthy and meaningful and dependable and more likely to fill a gap such as loneliness.*
>
> *For those people that I do work directly with, I still cannot bring myself to say "I am not your friend". I accept and respect that they may see me in that way, after all, I am a person in their life who is important to them, someone who helps them when they are having problems, someone that listens to them when they are upset, someone that shares their learning and leisure activities, someone who even shares their bathroom and kitchen or spends the night in their house. If I am doing this in a way that the client finds comfortable and helpful and meaningful (which I hope I am) then is it not likely that the client will see me as a friend?*

This is reinforced by a mum who says

> *My son's support workers are great and are the only ones who (apart from us) can "get through" to my son. It takes a lot of time and patience to get to know him, and also a lot of confidence to do things with him. I have tried in vain to*

> *get young people to join his Circle of Friends, but they are all too busy to take the time to get to know him and learn how to communicate with him. We have older people in the Circle who will take the time to come to a few get-togethers, but only if I organise them. Again, none of them really know him or can communicate with him. Also, I am quite sure they are all scared stiff of him as he does have very challenging behaviour. They are ok if he has his support workers or his family members with him, but no-one would spend time with him or take him out unless they were a former worker. We do have some former workers who do keep in touch with him, but they are very busy people with their own personal lives to lead, so they don't see him very often either. So, although it makes us very sad, I am afraid to say that that the only true friends my son has are support workers. They think the world of him and often do things for him which exceeds their "duty" - for example - laying on a party for him and attending the party in their free time (apart from the one who was on duty!)*

In response, Sheppard (2009) said,

> '*If people with learning disabilities think their paid support staff are friends then what is the impetus for making real friends? If you think you already have friends and* you *don't that is a lie!' ...to pretend to be someone's friend when you're not is abusive and patronising to people with learning disabilities. ... And no, I wouldn't necessarily want the person helping me to be my friend.'*

Rethink declare that staff must ensure that working relationships are not misread or confused with friendship or other personal relationships. This might be difficult – Lawson (2009) found that 95% of his sample of around 90 adults with learning disabilities considered their support staff to be their friends too. Some people who employ their personal assistants may sidestep all the professional discussions by simply selecting staff who are willing to be their friends. Meanwhile, Fischer et al (2008) indicate that a patient who stays awake in order to greet a night-shift nurse is a 'red flag' indicating a possible boundary violation by the nurse.

L'Arche was established in 1976 and now comprises 150 people who together form a community in which people with and without learning disabilities share as equals, celebrating the gifts that each member brings. Thirty people have a learning disability, about 70 have an employed role, and the rest are volunteers. It is one of many similar communities worldwide. A regulatory body has recently criticised the fact that 'staff' are spending leisure time with disabled people, by attending football matches and so on, and that friendships are forming between them in a way that

could lead to reciprocal invitations to hospitality outside of work and in people's homes.

L'Arche (2008) define friendship as a mutual relationship occurring 'with people we have known for a time, feel safe with, and who we genuinely like and therefore want to have them as part of our life.' They go on to imply that friendship is sustained outside and beyond the formality of a working relationship, since it is chosen and voluntary rather than the assigned and received asymmetric relationship between the person and their support worker.

#6: Are you using similar words to mean different things?

One problem with this is that a term such as 'friendship' actually carries a wide range of possible meanings. One writer to the Choice Forum suggested that it was the issue of enforced responsibilities that was the crucial difference between a friend and an empoloyee:

> *'As a support worker you are in a position of responsibility, no matter how independent someone is, you are required to do things that you have no choice over. As a friend you don't have to.' (24 March 2009)*

Table 1 contrasts three views of friendship - Spencer and Pahl's ethnographic study of friendship (2006); CHRE's (2008a) attempt to eliminate sexual exploitation by staff and a professional nursing body seeking to regulate members' conduct. By presenting models of friendship, community or other topics that carry unexplained assumptions or inherent flaws, these approaches inadvertently propagate the very practices they rail against – they are unreflective rather than encouraging conscious and responsible consideration of all pertinent issues.

Health and social care staff frequently find themselves negotiating these issues and therefore need to avoid over-simplification in their use of language and assumptions about the defining qualities that make a friendship. By no means all types of lived-out friendship discovered by Spencer and Pahl would fit the CHRE theorising about the nature of friendship. Meanwhile, *L'Arche* warn team members to take their cue from the person and not apply the term 'friend' where this is not the case, as it could be 'patronising, untruthful and possibly manipulative.' Time is needed to discern the nature of the relationship, as well as the objectivity and scrutiny provided by others who know each person.

One of the key drivers for inclusion work is to assist people to build relationships with people who are not paid to be in their lives – a recognition that this type of freely chosen relationship has a quality about it that is fundamentally different. However, if the fact of payment makes all the difference, then we should be very wary indeed about encouraging people to spend their personal budgets on employing their

friends, since it will destroy the foundations of that relationship. Perhaps it is possible for the payment to be incidental to the informal relationship and people can be friendly with the people they employ or who are employed to support them. As one mother put it:

> *‘My daughter is considered without capacity... so how she could be expected to understand commercial relationships as opposed to friendships I do not know. It is not up to us to explain to her the dangers of paid employees being thought of as friends. It is up to us to figure out how to be good friends... It takes giving support to our emotional and spiritual development and taking care of our interconnectedness. Even when people leave the 'job' they remain friends. This can be hard work, but it is a million times more successful than any other 'package' of care we have experienced. ...No person gets to develop without becoming 'attached'. ...No matter how good someone may be at personal care, if they can't also just be with my daughter, we suspect they belong somewhere else.’*

Table 1: Different viewpoints on friendship

Friendship Types (Spencer and Pahl 2006)
1. Associate – share a common activity 2. Useful contact – pull strings, share information 3. Favour friend – practical help 4. Fun friend – light hearted socialising together in a variety of settings 5. Helpmate – call on in need 6. Comforter – emotional support 7. Confidant – sounding board for sharing secrets 8. Soulmate – a kindred spirit who knows you inside out and is 'on the same wavelength'
Friendship versus Professional Relationship (CHRE[1] 2008a)
1. Mutuality vs. one-way benefit 2. Freely chosen vs. assigned 3. Symmetric vs. asymmetric disclosure of information 4. Informal vs. formal sanctions for breach of confidentiality 5. May feel hurt or angry by the actions of the other vs. not taking it personally 6. Feelings of love can be expressed by hugs, kisses or sex vs. prohibited. 7. Exchange gifts vs. almost never do so.
Non-professional versus professional relationships (CRNNS 2002)
1. No payment is made vs payment or useful experience gained 2. The relationship may last from a day to lifetime vs. duration is limited by the work to be done and often delivered in managed units (e.g. 50 minute interviews) 3. Could happen in any location vs setting is defined by the work to be done 4. Purpose tends to be pleasure, interest, social interaction or shared interests vs purpose is to help the service user by providing support and care 5. Relationship structure is spontaneous and informal vs structured by the support role and task. 6. No formal knowledge, preparation or training is needed to engage in the relationship, vs training and ongoing development is necessary to enable the care and support to be delivered.

[1] "The Health Professions Council (HPC – now enlarged to become the Health and Care Professions Council with more members): this is the regulatory body covering more than 13 professions. Each of these professions has at least one professional body giving advice and publishing guidelines. However, the HPC deals with fitness-to-practice cases. It keeps a register of professionals and publishes several sets of standards which are referred to in the fitness-to-practice cases. Most relevant to the discussion of professional boundaries is the standards of conduct, performance and ethics (available online). The standards are reviewed as a matter of course every five years, the next review being due in 2011/12. The Council for Healthcare Regulatory Excellence (CHRE) oversees nine regulatory bodies of which the HPC is one. This involves *inter alia* an annual performance review, a scrutiny of all fitness to practice decisions (around 1000 annually), and referral of cases to the High Court if the CHRE believe the regulatory bodies have been too lenient." (Doel et al 2009)

In stark contrast to those who claim to be able to cleanly distinguish the professional from the personal, Freud and Krug (2002) conclude a case study with the haunting words, 'this example shakes our certainty regarding the differences between friendships and professional relationships.'

A multi-strand relationship rope....

We can picture most relationships as made up of several different strands, rather like a rope, and single-strand relationships are perhaps rare and hard to sustain (Llewellyn 2002). Ultimately, all relationships are multi-strand, as we are all citizens in the same society. Even if we don't interact, our spouses or friends or colleagues may know one another.

The image is unsatisfactorily inanimate, but it serves our purpose. Some individual strands may be thicker, stronger or coloured more brightly than others, illustrating the differences in perhaps depth of trust or disclosure that occurs in that strand, while others are thin, representing informal, superficial but nevertheless important connection between the two people. Putnam (2000) and his predecessor Granovetter (1973) have shown the value of weak strands in building community, identity, self esteem and social inclusion.

Freud and Krug (2002) describe the school social worker as a therapist, emotional and social educator, mentor, role model, family and community liaison, crisis worker, disciplinarian and even lunch monitor. Multi-strand relationships are the norm.

Each strand of relationship is conducted according to its own conventions. Galbreath (2005 p 107) advises that: 'explaining early on in the professional relationship the different roles you may play in the client's life may help the client understand why you behave differently in your professional role than in the role of the non-professional.'

We might label the strands that go together to form the rope. Peternelj-Taylor (2003) distinguishes the professional relationship from the workplace social relationship, and thus creates a two-strand version. It is worth noting here that the term 'dual relationship' has sometimes been taken as a euphemism for a sexual relationship with a therapist and so has been unhelpfully linked with exploitation and abuse.

...with interactions between the strands

The rope image helps us think about different kinds of relationship that may occur concurrently between two people and it suggests that one strand might affect others. The rules of confidentiality, for example, may be understood quite differently in the community setting and the therapy room, and so cause misunderstandings, confusion and even conflict as roles and relationships are blurred. Such misapplication of rules from one setting to another is more likely with unskilled or inexperienced workers or where either party has a ‘rule-breaking’ personality.

Some relationships may be suspended whilst therapy is taking place and picked up again after it is complete. Fisher and Goldsmith (1999) seek a middle way in which the worker and the person, faced with a potential dual relationship that includes a close personal relationship in which they spend substantial amounts of time together outside of service provision, choose which of the two relationships they will continue. One regulatory body addresses this dilemma by indicating that it is it is ‘never appropriate to terminate a therapeutic relationship with the intention of pursuing a social or sexual relationship.’ (CHRE 2008b).

In the wider society, the distinction between different strands appears to be maintained most of the time through unspoken cultural norms, and so people with attractive skills spend comparatively little time fending off untimely requests from their potential customers, patients or clients. Indeed, rather than rejecting every attempt at communication, some entrepreneurs welcome these minor ‘boundary violations’ at a party, for example, as a marketing opportunity, and use them to negotiate a suitable meeting time in which to conduct a proper consultation or sales pitch. Others use their shared membership of a club or network to gain preferential treatment in business. At the same time, the vast majority of participants, on both sides of this negotiation, understand exactly what is happening and work equally hard to re-erect the boundary.

But the rope image is not very good at representing how relationships can evolve or occur consecutively over time. For example, I might get to know someone at the squash club and then ask them out on a date, get married, and continue to play squash with them until our baby’s arrival prompts a lifestyle change. The image of rope does not work too well for situations of this kind and so other approaches have to be utilised.

#7: Do inexperienced workers receive extra support?

Freud and Krug (2002) observe workers who assume ‘once a client, always a client’ and so are reluctant to terminate their professional relationship or allow a new form

of relationship to emerge, while others view their professional obligations as ending after the work is done and so anticipate people moving on. They ask why we should assume the inevitability or even the desirability of maintaining client-worker relationships throughout life?

Boundary crossings and violations

Boundary theory has developed as a response to the challenge of avoiding harm whilst establishing a caring relationship. A literature search turned up over 1500 papers on the topic (Pope and Keith-Spiegel 2008). Despite this large tally, the discussion has not engaged with the transformation of social care in the United Kingdom. Parkes and Jukes (2008) remark that, 'a search of the current literature on self-directed care and personalisation in services reveals little discussion on personal boundaries.'

We all use boundaries when we ensure that supervision time is used for its intended purpose and when we go home at the right time. A professional boundary (or 'professional distance') is a metaphor for the rules and limits surrounding the worker/service user relationship. It can be constructed from elements such as role, language, time, place, space and physical contact, clothing, money and gift exchange, contracting for services, self-disclosure and record keeping (Malone et al 2004). The American National Council of Boards of Nursing describes boundaries in terms of a "Continuum of Professional Behaviour":

> "*A zone of helpfulness is the centre of the professional behaviour continuum. This zone is where the majority of client interactions should occur for effectiveness and client safety. Over-involvement with a client is on the right side of the continuum; this includes boundary crossings, boundary violations and professional sexual misconduct. Under-involvement lies on the left side; this includes distancing, disinterest and neglect, and it can also be detrimental to the client and the nurse. There are no definite lines separating the zone of helpfulness from the ends of the continuum; instead, it is a gradual transition or melding.'* (Quoted in Fischer et al 2008).

Workers can retreat behind these boundaries to avoid difficult clients but out in the community there are fewer places to hide. Both creating and then choosing to cross the boundary are demonstrations of the power of the worker.

Workers often say that emphasising and upholding boundaries is a valuable intervention in its own right, as if highly regulated societies produce better citizens than those with fewer laws and police. A 'boundary crossing' is a decision to briefly

deviate from an established boundary, whilst remaining within the framework of the law, for therapeutic purposes. This is differentiated from a 'boundary violation' which is harmful, exploitative, manipulative, deceptive or coercive. Doel et al (2009) distinguish obvious violations from the grey or ambiguous areas that they term transgressions or the penumbra.

Pugh (2007, p1419) points out that the definition of a crossing is rooted in the benign intention of the worker, whilst a violation is identified by its real or potentially harmful consequences. Meanwhile, Freud and Krug (2002) give several examples of good deeds done by a social worker that genuinely benefited a service user, but were kept secret from colleagues, as the worker feared that some other principle, such as perhaps favouring one client over another, was breached by the act of kindness.

Parnham (2007: 42) described an example of a boundary crossing in which a counsellor accompanied her client to the cemetery to visit her baby's grave. There is always the risk that the client may interpret the gesture as a signal that the worker wishes to change the nature of the relationship. In contrast, it is the intentional exploitation that characterises a violation, as highlighted in the regulatory body's definition, 'A breach of sexual boundaries occurs when a healthcare professional displays sexualised behaviour towards a patient or carer. Sexualised behaviour is defined as acts, words or behaviour designed or intended to arouse or gratify sexual impulses or desires.' (CHRE 2008)

The various self-assessment tools that have been developed suggest that indicators of problematic boundary-keeping include a disproportionate amount of time spent with particular clients, both on and off duty, feelings about particular individuals, such as viewing people possessively as 'my client' (rather than *our* shared responsibility) or seeing the person as special; planning work with other service users around the needs of the favoured person; acting impulsively in relation to the person; frequent touching (more than 'normal'), issues surrounding self-disclosure and keeping secrets; role reversal, thinking about them frequently when you are away from work, fantasising about the person, inability to explore feelings and responses towards the person and prominence of the worker's personal needs, perhaps sharing work concerns or unusually personal details with them. Personal needs can be very practical, such as buying a couple of personal items whilst supporting someone to do their shopping, bringing a sick child to work or changing arrangements in response to staff shortages. In an unsupported assertion, Walker and Clark (1999) observe that disclosures of highly personal information are rarely welcome or justifiable.

Whilst we have a shamefully large volume of evidence that exploitative and abusive relationships are damaging, comparatively little has been written from the

perspective of the person receiving services about multi-strand relationships that are not self-evidently damaging, and the power differential further silences their voice.

This shows that boundary violations can be subtle or extreme breaches of trust. As a stark example, Disch & Avery (2001) surveyed 149 survivors of sexual abuse perpetrated by medical or mental health professionals or clergy.

Whilst we again emphasise our shared duty to protect vulnerable people from abuse, Radden (2001) has argued that the entire notion of a rigid boundary is faulty. We note that a common organisational response to a boundary violation is to move the boundary, thus reducing discretion and flexibility, rather than simply re-erecting it.

The slippery slope

Kagle and Giebelhausen (1994:218) declare that "Practitioners found to have engaged in any dual relationship should have their certifications revoked and their memberships in professional associations terminated." Malone et al (2004) say 'When the [mental health service] provider becomes a friend, employee, associate, or sex partner to the client, an additional relationship exists and the boundaries of the therapeutic relationship are breached.'

In this view, all boundary violations, even the most trivial, are seen as the first step down a slippery slope that leads inexorably to an exploitative sexual relationship between the worker and the person. This can be extended to a concern about any kind of relationship between the person and a member of the public, with either side being seen as wilfully seeking opportunities to 'groom' or exploit the other (DH 2008). This is reminiscent of the repressed eugenic discourse about protecting the public from the unfettered sexuality of marginalised people.

Furthermore, Peternelj-Taylor (2003) adds that 'many nurses are oblivious to the fact that they have been drawn into crossing the boundary until they are well over it' and so gradual boundary erosion leads to a progression of increasingly unethical patterns of behaviour.

Similarly, Pope and Keith-Speigel (2008) assert that only a minority of boundary violators do so in a deliberate and calculating way, while 'many cases reveal a spiralling downward of incremental, tiny, rationalised steps into a quagmire that ultimately astounds even the offending therapists themselves as much as it does the rest of us.' Reamer (2003) somewhat redeems this area by offering a category of 'altruistic gestures' that nevertheless can create boundary dilemmas.

Because of this, they say, it is necessary to adopt a zero tolerance position. Others disagree (Lazarus and Zur 2002). In contrast, Bournemouth Social Services have a rule that, 'It would not be fair or desirable to prevent all contact between Home Care Assistants and service users outside the work relationship. Many Home Care Assistants support service users in a voluntary capacity outside the formal working arrangement. This is not discouraged but must take second place and must not conflict with the professional relationship.'

Zero Tolerance

We need to hastily point out that there is a comprehensive legal framework in which sexual boundary violations are, quite properly, recognised as harmful. For example, the Sexual Offences Act (2003) sections 38-41 create specific offences for a care worker that engages in sexual activity with a mentally disordered person who receives care in the setting where they work. Sexual boundary violations are also proscribed by the professional regulatory bodies. For example, the Nursing and Midwifery Council (NMC 2008) says that 'you must establish and maintain clear sexual boundaries at all times with people in your care, their families and carers.' The *Independent Safeguarding Authority* will no doubt make clear statements on this important issue and guidance is being revised in the light of the Protection of Freedoms Act 2012.

#8: Do workers feel safe enough to disclose anxieties about their own or each other's conduct so that problems are identified early?

There is a long history of attempts to extend the framework of prohibitions in order to safeguard vulnerable adults, perhaps because rigid boundaries are easy to regulate. As Doel et al (2009) put it:

> *bullet points of prohibitions, warnings and injunctions can grow like topsy, but it is unlikely that when a transgression occurs it is the result of a missing bullet point. (section 1.3)*

However, as shown by Spiegel et al (2003), this does not completely address the issues, even in the extreme situation of illegal sexual relations between the worker and the person. They suggest that a zero tolerance position in which workers are portrayed as asexual blocks the essential discussion of how to acknowledge and deal with feelings of personal affinity. Such honesty demands subtlety, since acknowledging sexual dynamics, and the attendant embarrassment, fear, guilt and shame, is not the same as tolerating sexual abuse (CHRE 2008b).

Whilst blanket prohibitions correctly forbid sexual abuse, they do not assist in resolving dilemmas about informal relationships in which friendly gestures, co-participation in leisure activities and informal companionship occur on a daily basis. Along with Gonsiorek and Brown (1989), I suggest that the rules for nonsexual dual relationships should be formulated apart from rules regarding sexual contact. In addition, the same principle of preferring honest explorations rather than the denial and objectification generated by zero tolerance prohibitions may apply all the more to the other kinds of relationship too on the spectrum of social contact, and not just sexual relationships.

I also note and challenge the negative and pessimistic values that are carried by the slippery slope image – that boundary crossings can never be therapeutic, that minor crossings are motivated by a malicious desire to violate, and that both the therapist and the person are unreflective, helpless victims of this harmful gravitational pull.

Where policy or academic statements vehemently denounce dual relationships, workers may react with fearful silence rather than discussing the situation and possibly negotiating a transfer to another worker as a means of resolving the problem of sexual attraction or emerging role conflict. (CHRE 2008b). It is notable that, while the regulatory body declares that 'a considerable percentage' of staff know of a colleague who has committed an offence by engaging in a sexual relationship with someone using the service, the self-report figures are very low (CHRE 2008b), reinforcing the point about staff difficulties in talking about the subject. Cooper and Jenkins report on a study of that found 8% of New Zealand's physiotherapists had engaged in a sexual relationship with a patient. Meanwhile, the Ohio Board of Nursing reports that less than 1% of the 4,000 complaints it investigates annually involve boundary issues and almost all of those that lead to disciplinary action consist of egregious behaviour rather than ambiguous or subtle judgements (Fischer et al 2008).

Sometimes a zero tolerance position resolves itself into a simple prohibition that treats people using services as a homogenous group. We note that such judgements made simply on the basis of disability are outlawed as discrimination by the Disability Discrimination Act 1995, and even the UK security service has been obliged to treat people on a case-by-case basis (DCA 2006 footnotes 61, 64).

Furthermore, an undue preoccupation with ethics at the boundary may divert attention away from the broader discussion of ethical interventions per se. So a technical, non-contextualised application of boundary standards may morally impoverish the workforce (Freud and Krug 2002) and erode the commitment to act ethically down to a focus on compliance with rules.

In contrast:

> *“A notion of ethical engagement is presented as critical to helping professional and managers to navigate through difficult professional boundary issues. Ethical engagement is a process whereby the ethical issues that underpin professional boundary dilemmas are regularly discussed and addressed - in the supervision of staff, in team development work and in the everyday practices of the organisation. In this way, codes of conduct are not seen as insurance policies to be dusted off when something goes wrong, but as an active document, developed out of everyday practices ('bottom up' rather than 'top down') and seen as credible and relevant by those who work with professional boundary dilemmas day by day.” (Doel et al 2009 section 1.3)*

Simple prohibitions

These may be formal written statements or tacit beliefs, and tend to be simple and memorable – do not live here, do not invite, do not visit, do not disclose, do not touch, do not share leisure time and space, do not give or receive gifts. Doel et al (2009) note that the American National Association of Social Workers almost doubled its list from 80 to 155 prohibitions in 1999. These over instructive diktats are likely to be no more effective than over-vague principles.

Do not live here. ‘Do not live here’ was common in social work, where staff were directed to live in a different neighbourhood to the place where they worked. In contrast, many clergy are required to live in the parish where they work.

Do not invite people to your home. The day service in Leicestershire includes an individual support service that has been running for 20 years, and through which people using the service spend time in the ordinary living area of the home of self-employed carers. Such ‘Adult Placement’ schemes create informal dyads (single worker and person) that spend time together, access local community opportunities and negotiate boundaries between work and family life on a daily basis.

Workers in the Leicestershire day service are obliged to disclose a considerable amount of information about their own lives, simply by welcoming the person into their own home, and then have discretion about how much more to choose to disclose. This is in marked contrast to the counsellor who puts away the desktop photograph of their children in order to maintain the principle of anonymity and highlight any transference that may occur. It is

> #9: Are there particular teams or services where the overall policy is seen as inapplicable? What arrangements are made for them?

worth noting the place of worker choice here –that staff should not feel obliged to place their personal lives at the disposal of the service and may exercise their right to privacy.

Do not go there. Rethink cryptically refer to 'inappropriate meeting places' but do not specify what these might be. Walker and Clark (1999) suggest that there is an increased risk of blurring of roles if a long time is spent in a car, in the home or in non-office settings, which may prove challenging to volunteer drivers and home helps.

Do not visit people at their home. The regulatory body identifies some behaviours which, 'while not necessarily constituting a breach of sexual boundaries, may be precursors to displaying sexualised behaviour towards patients. These behaviours include... visiting a patient's home unannounced and without a prior appointment.' (CHRE 2008b). Walker and Clark (1999) proscribe home visits that are outside 'sanctioned interventions' and Linda Coote was sacked for breaching a vulnerable adults policy by visiting a terminally ill man in her own time, just two days before he died (Faughey 2008). Freud and Krug (2002), similarly describe (with some surprise) a social worker in a mental health clinic who did not undertake home visits at all in an attempt to 'keep the relationship on a professional basis'.

Do not disclose to anyone your home address, telephone number, or anything about your family or interests. Walker and Clark (1999) say that frequent lengthy telephone calls with a service user, especially late at night or at the weekend can indicate boundary problems. Brodsky's 1986 research found that the typical therapist who is sued for sexual misconduct commonly disclosed his personal problems to the clients with whom he is sexually involved. In contrast, Pope and Keith-Speigel (2008) offer questions to help workers decide on whether to disclose personal information or not.

Is your planned self-disclosure:

1. Consistent with the person's needs and the goals of your intervention?
2. Consistent with the kind of work that you are doing?
3. To mainly meet your own needs?
4. Right at this point in time?
5. Likely to involve risks, costs or downsides? What are they?
6. A departure from your usual way of working?
7. Easy to write up and discuss with your manager?

Walker and Clark (1999) say that professionals who disclose personal circumstances to clients open the door to boundary problems. Freud and Krug (2002) intriguingly suggest that self-disclosure, gift exchange and physical touch might be appropriate with the aged or children.

Do not form a friendship. This has been discussed already..

Do not touch is commonly considered to be the rule in many care settings and in statutory education. Walker and Clark (1999) say that physical contact is generally regarded as high-risk behaviour. Cooper and Jenkins (2008) suggest that physiotherapists frequently develop a close physical relationship and an emotional attachment with their patients that is almost unique within the healthcare sector, and this observation reminds us of the interplay between touch and relationship building – it might almost be described as a contact sport.

Our society's sexualised interpretation of touch combines with the proper censure of sexual abuse to deny people who live in care environments this basic human need. In contrast, government tantalisingly acknowledges that appropriate touch can be part of a therapeutic relationship and similarly, watching a person undress may be an appropriate action for a worker observing a patient on suicide watch or a care assistant helping with activities of daily living. (CHRE 2008b). The Royal College of Psychiatrists advise their members that one of the signs that a therapist or nurse is improperly crossing the patient-therapist boundary is repeatedly touching or hugging the patient (Policy 1.45 paragraph 5.5). Well intentioned touch may, of course, be interpreted as sexual by the other person, and this risk may be amplified by power inequalities. NASW (2000) require social workers to set clear, appropriate and culturally sensitive boundaries in relation to physical contact. Indeed, cultural factors come into play as in communities where kissing is the usual form of greeting and does not carry an erotically charged meaning.

Do not share leisure time. CHRE (2008b) says that 'giving or accepting social invitations' may not necessarily constitute a breach of sexual boundaries, but may be a precursor to displaying sexualised behaviour. Rethink describe socialising with a service user as a 'clear unacceptable practice'. The Royal College of Psychiatrists advise their members that one of the signs that a therapist or nurse is improperly crossing the patient-therapist boundary include is non-therapeutic contact outside of the hospital (Policy 1.45 paragraph 5.5).

Many agencies have a 'no drinking alcohol on duty' rule, while Rethink include drinking with a service user at any time as unacceptable.

A particular issue may be the invitation to attend a rite of passage, such as a wedding. Sometimes the secret wish is for the invitation to be made and then politely declined.

Do not give or receive gifts. Reamer (2003) describes gift exchange as an intimate gesture. Nurses are told (NMC 2008) 'you must refuse any gifts, favours or hospitality that might be interpreted as an attempt to gain preferential treatment. The College of Occupational Therapists (para 4.5 of their Code of Conduct) prohibits members from accepting tokens such as favours, gifts or hospitality from clients, their families or commercial organisations when this might be construed as seeking to obtain preferential treatment.

The Royal College of Psychiatrists is a little more flexible: 'Boundary crossings may be accidental or thoughtless or intended as kindness or courtesy. They can also be trivial. In certain circumstances a member of staff may intentionally cross over to meet a specific need. For example, one may: give a gift that encourages, teaches or meets other therapeutic purposes, such as an inspirational book signed by the staff member' (Policy 1.45, paragraph 5.3). However, they say that one of the signs that a therapist or nurse is improperly crossing the patient-therapist boundary is 'giving or accepting a valuable gift or loan and excessive exchange of gifts' (Policy 1.45, paragraph 5.5).

Walker and Clark (1999) note that gifts may be loaded with additional meaning, such as a small gift that happens to be given near Valentine's Day.

DH2008,p38 says, 'Financial abuse of vulnerable adults is a growing problem, with many offences going unreported. Often committed by family members or informal carers and due to the sometimes vulnerable mental or physical condition of the victim, difficulties arise in obtaining admissible evidence. Financial institutions are raising concerns informally with the police about unusual financial transactions on vulnerable people's accounts. This may in fact be the 'tip of the iceberg' and financial abuse may be more widespread than reported incidence suggests.'

Naming the wounds

A broad definition (NASW 2000) suggests that dual relationships generate conflicts of interest that interfere with the exercise of professional discretion (confidential matters may be inadvertently disclosed) and impartial judgement, or where workers obtain undue influence and so further their own personal, religious, political or business interests.

A rather more sophisticated approach attempts to set out more precisely the nature of the prohibited behaviours and the harm that is caused by it. A good example is the New York Office of Mental Health policy which identifies the following areas where boundary violation may cause harm:

> #10: How wide is the gap between the written policy and what people actually do? Why? In revising your policy, are you drawing on the wisdom and experience of people at the grassroots?

1. Sexual contact – any touching of the sexual or other intimate parts of a person's body with the intent of gratifying sexual desire of either party.
2. Sexual behaviour – engaging in any form of communication intended to promote or produce sexual contact; and/or sharing or providing sexually stimulating media, irrespective or any physical touching or sexual contact
3. Commercial advantage – the purchase or provision of goods or services at other than fair market value
4. Exploitation – the use by an employee of a patient's person or property or the treatment or service provision relationship in a manner that results in, or is intended to result in, personal profit or gain (beyond the employee's authorised compensation) or personal advantage for the employee. Reamer (2003) notes that relatively brief, casual and non-exploitative conversations with clients concerning topics on which clients are expert may empower clients, facilitate therapeutic progress and challenge traditionally hierarchical relationships.
5. Close personal relationship – one on one interaction between a patient and an employee in which a substantial amount of time is spent together outside of the context of the services that constitute a patient's treatment plan
6. Commercial relationship – an exclusive interaction between a patient and an employee which involves the purchase or provision of goods or services (other than mental health services) at fair market value. For example, Bournemouth Social Services have a rule that 'Home Care Assistants are prohibited from entering into any paid private arrangements with service users of the Home Care Service for work outside their employment with the Council.' (Henley 2009)

Rethink note that failure to maintain proper boundaries may lead to favouritism or neglect. In passing we note that a worker exercising favouritism of one person over another on their caseload would be unacceptable, while the variations between the

even-handed approach of one worker and another will arise for a variety of reasons, of which variations in boundary-keeping will be just one. Stamping out differences driven by person-centred practice, personal style, level of enthusiasm and so on would require a substantial project that would almost certainly dehumanise the whole service.

Further wounds are discussed by Doel et al (2009), including damaging public confidence in the employer or the profession.

Prohibitions, whether simple or sophisticated, are usually set out in a policy. A further difficulty arises when there is a gap between the written policy and staff action. Indeed, it is commonly the case that practice is more strongly determined by the 'tacit policy' rather than the written one. Thus, some of the regulations that frontline staff believe to be required of them are not found in their own organisation's formal statements at all, and other teams within the same organisation have their own local, tacit regulations. Similarly, even where people know the official line, they may not comply with it, creating a difference between the official discourse and sub-cultural practices.

#11: Which workers and activities definitely need to avoid all other contact?

The task of the regulatory bodies is particularly challenging, since there appears to be so little consensus about what constitutes a boundary violation. The former chair of BASW, Ray Jones, describes occasions when he has socialised with people using services in his own home (Mickel 2008), while Williams lists occasions when such behaviour formed the basis of a prosecution.

The bulk of easily accessible guidance from professional bodies[1,2,3,4,5,6,7,8,9] concerning professional boundaries was described by the manager of the Leicestershire service as almost entirely irrelevant to the subtle challenges faced by her service. Pugh (2007) concurs: '*with the exception of intimate or sexual relationships, the General Social Care Council codes of conduct offer no specific guidance on multiple or dual relationships.*'

The therapeutic relationship – in the counselling room

In an attempt to prevent the development of harmful relationships between staff and the people they support, the day service for people with learning disabilities in Durham rotated their staff every four weeks, disrupting the slow development of

trust, any understanding of idiosyncratic communication and building of relationships with mainstream community organisations.

Rather than Durham's approach of 'no relationship', some psychologists have argued that the therapeutic relationship has most effect when it is uncontaminated by other kinds of bonds. The idea may be drawn from aseptic surgery, where a protective barrier between surgeon and patient prevents the transmission of infection, or from hard science's notion of objectivity, which views the worker as a neutral observer, detached and unaffected by their own history or the community of which they are a part.

This has been reinforced by litigation in the US, where therapists have been subject to censure for engaging in dual or multiple relationships on the basis that going for a walk or sharing a sandwich at lunchtime, for example, constitutes a 'slippery slope' boundary violation. The therapist should rather remain anonymous, opaque, a blank screen, focused upon the person rather than themselves, sharing nothing of their personal lives for fear of contaminating the therapeutic relationship, especially its projective elements.

It is clearly the case that the counselling room and its attendant power imbalance can lead to the therapist being seen as powerful, all-knowing and even sexually irresistible, and that these responses are best dealt with in the comparative simplicity and predictability of a single-strand counselling relationship rather than the complex arena of the community.

There are precedents in ordinary life for a single strand relationship – such as the popular advice to 'never buy a used car from a friend' and the commonly held view that when entering the confessional or the counselling room, one's disclosures need to go to a stranger, rather than a person you will see regularly.

#12: How do you stay in touch with legal and professional disciplinary actions that may influence your approach?

However, Freud and Krug (2002) warn that 'the mystique of the tightly boundaried, hierarchical therapeutic relationship heightens transference phenomena.'

We will need to explore whether this simple regulation is practical, helpful and appropriate for all health and social care employees, and under what conditions it might be entirely appropriate. We also need to be alert to the danger of feigning ignorance about any other strands of the relationship that may exist between the worker and the person and between the person and the community, and instead use thoughtful and consenting disclosure with both the person and the community to harness the power of these wider connections.

In contrast to this cautious, deliberate and calculating encounter stands the idea that a genuine meeting between people demands that you put your whole self in – that you engage in mutual dialogue with the possibility of being changed yourself in the process. Whether derived from disability politics, emancipatory research or anthropology, these approaches seek understanding through engagement rather than understanding through detachment.

#13: Are you drawing on the lived experience of people who have used services to form your workforce and how do these staff maintain appropriate boundaries?

Peer support workers, service user researchers and many other staff bring their personal, lived experience of mental ill health to the relationship, inspire hope and become a compelling role model simply through their authentic, transparent lives.

This desire for authenticity and personal integrity affects many workers (Pearson 2006), whether they have a lived experience of exclusion or not. *Partners for Inclusion*, *L'Arche* and other agencies that focus on building informal roles in the community for people with substantial support needs usually focus on the value of contacts with people who are not paid to be in the person's life. Staff may feel hypocritical if they are refused permission to engage with people using the service outside work time, whilst in their job they are asking others to put their unwaged, voluntary effort into the project of building a local community fit for everyone.

At the broadest level, changes in the mores of our society over the past several decades have reduced deference to professionals and increased the degree of informality and perhaps superficial friendliness through which relationships are conducted. People are curious about one another and like to understand a little of the whole person, rather than just the professional persona. Especially in rural communities (Pugh 2006) and interest groups, staff may be expected to answer questions so that the person can 'check out' the worker by finding out what other community members think.

From this perspective we have to ask if confidentiality rules are the acceptable cloak for shame and professional distance is the acceptable cloak for the discrimination that refuses to reach out to another human being and make a real connection. A therapist can be present with the person as an active listener, but absent as a personality, hidden in professional neutrality and detachment (Alexander, quoted in Parnham 2007).

A mental health group that examined these issues in the US (Psychopathology Committee 2001) concluded that the self-disclosure that occurs when people share

personal information provides an opportunity for benefiting the person using the service. Disclosing information about current or past difficulties can alleviate the person's shame and embarrassment while offering hope that things can change. At the very least, it reveals the worker as a 'real person' whose support thus has meaning. However, responsible workers have made a judgement that the self-disclosure is beneficial to the person, and so a degree of asymmetry remains.

#14: Do you utilise low-key community relationships to assist the social inclusion agenda – and does your policy support these endeavours?

The therapeutic relationship – in the corridor

A preoccupying focus on the intense relationships of the counselling room can lead to low-key interventions being ignored. Therapeutic benefit is accomplished in the mental health centre both through treatment interventions and through the low-key warmth and friendliness of therapists, receptionists and cleaners in waiting areas, corridors and chance encounters around the building. These off-task contributions by the therapist and all kinds of colleagues help to create and sustain a respectful and genuinely helpful milieu and some would value them as highly as the specific interventions. The OMH (2002) policy refers to these as 'basic acts of kindness'.

Peternelj-Taylor (2003) advises mental health nurses to ensure that even light-hearted banter on the ward corridor (the workplace social relationship) is conducted according to the ethics of the professional relationship – i.e. that the encounter is solely for the benefit of the person.

Similarly, promoting social inclusion demands both highly skilled interventions such as negotiating job retention, and low-key activities ranging from greeting a person using services in the street, introducing him to a friend or passing on the details of the local jazz club. It may be that some intense relationships involving highly skilled interventions that promote either therapeutic benefit or social inclusion require single strand rather than multi-strand relationships.

The therapeutic relationship – focusing on the future

The goals of the therapeutic relationship may include assisting the individual to reclaim their identity as an active citizen in a vibrant and diverse community. The therapist/client relationship with its focus on problems gives way to shared participation in the wider life and contribution to the community. As one worker put it:

> *'If a person has a positive experience within a relationship, which currently for most people is with paid supporters, then they may and will develop the confidence to form other relationships.'*
> (Choice Forum 11 March 2009)

> #15: Is there space in your practice and policy for the therapeutic relationship to transition into an informal community relationship based on shared citizenship and identification with a shared locality or community group?

The traditional formal therapeutic relationship has a clear beginning, middle and end – what Boje has termed a BME story. On referral, the therapist appears in the life of the person, is known only in the context of the counselling room, and disappears completely after the therapy is complete. The shift from client to citizen happens as the person ends the dependent therapy relationship where the entire focus is on herself, and resumes her mutual interdependent relationships in the wider community.

In the traditional model the worker may not occupy both roles, and so the community phase of this process must occur with new people. The relationship with the worker is quite unlike relationships that occur naturally in the community. There is no doubt that attempting to make a transition from this sort of relationship into an ordinary community connection such as a friendship would be full of challenges and difficulties, almost like ex-lovers trying to remain friends.

Commenting on sexual relationships between doctors and their patients, Spiegel et al (2003) assert that 'such relationships seldom develop into stable partnerships'. This may be based on the UK research undertaken by Russell (1993) who found that sexual dual relationships are exploitative, while parallel findings for non-sexual dual relationships in the US found these to be harmful too (Pope & Vasquez 1998). This raises the question of the generalisability of these findings and how much we really know about the quality, durability and satisfaction generated by all kinds of secondary relationships that occur alongside a professional one.

The professional relationship does not confer any entitlement to friendship beyond the workplace, but the person may feel that it should. Meanwhile, for her part, the worker may be unwilling to add current or ex-clients to her circle of friends and acquaintances. Some client-friends may wish to move fluidly between these two strands of relationship in a way that does not suit the worker.

Despite these difficulties, it may be possible for the therapeutic relationship to evolve into a community relationship, and the dual or multi-strand relationship can be seen as a helpful midpoint on this journey (Parnham 2007, P58).

The artificial relationship with the worker may be acceptable if it forms only a tiny percentage of the person's whole life, but some people have few informal, unpaid relationships outside the caring service. Addressing the person's true needs would involve encouraging them to take a positive interest in other people by modelling this in the worker/client relationship prior to encouraging such behaviour in informal community relationships. In this way, workers should make increasing demands for personal attention until the one-way therapeutic relationship is equalised and is conducted like any informal community relationship, thus completing the preparation of the person.

The future focus of the therapeutic relationship breaks down when staff become dominant and encourage dependency. Rachel Perkins encountered a user group who claimed that they could not possibly have a game of bingo unless there was a CPN present, and in Perth I was told that the safeguarding regulations meant that there had to be a minimum number of staff present when a group of people using the service met one another, just like the staffing levels required for registered child care centres.

The therapeutic relationship – in the community

Sonne (2005) distinguishes incidental, brief contacts in the community from 'intentional, ongoing and substantive social interchange' and in a similar vein, Reamer (2003) refers to '*unanticipated circumstances over which the worker has little or no initial control'*. Fischer et al (2008) report that boundary violations that are reported to disciplinary committees tend to be those involving gross rather than subtle incidences of misconduct, and such behaviour tends to be prolonged, recurring financial or sexual abuse of extremely vulnerable people. Brief, incidental contacts tend not to be reported.

Freud and Krug (2002) suggest that accidental or minor social or business contacts with a current or former client is neither a dual relationship nor a boundary crossing and should be dropped from the list of legitimate ethical concerns. This is where the principle of proportionality applies.

L'Arche extend this binary contrast of incidental and prolonged community contact by suggesting a hierarchy of situations, ranging from a chance encounter at a gym, through meeting a group in a pub to inviting a service user to an overnight stay at your home or taking a holiday together.

Seemingly incidental and brief contacts may be disproportionately influential, however: Clare Allan reports how she bumped into her social worker in the street.

“"How nice to see you," she said, and it was clear to me that she meant it. The mere fact that I remember such a simple comment all these years later suggests just how potent sincerity can be. At the other extreme, we also need to note here that ‘the community’ can be reduced to simply another therapy site, redefined as an extension of the counselling room or the art therapy studio.

Community development work involves meeting citizens on their own terms, building informal relationships and supporting activism driven by their priorities. Purposeful cultivation of dual relationships may be necessary for successful entry into the community, professional legitimacy and knowledgeable intervention (Freud and Krug 2002).

An increasing number of mental health and learning disability staff job descriptions in the UK include the task of promoting social inclusion. Staff find out about the person’s positive social roles in the past and present and their aspirations for the future and help them to rebuild or develop as employees, friends, students, neighbours, and participants in social, leisure and citizenship activities. Bridge-builders find out what people want to do, help ordinary community groups to become welcoming and respectful places, and assist people to join in. This can be brief work, largely achieved through signposting the person to a suitable activity or a specialist adviser, or intensive work in which considerable effort is expended in exploring barriers, coaching, co-participating and gradually handing over to informal supporters in the setting.

Bridge-builders harness their own personal networks of connections, engage their friends and acquaintances in the search for suitable opportunities, extend their network at every conceivable opportunity, and provide skilled reassurance to mainstream community groups, but often in very informal ways (McKnight 1995).

We note that Bridge-Builders are often much less well trained or paid in comparison to their clinical counterparts, but find themselves in the more complex, challenging and ambiguous environment, surrounded by multi-strand relationships.

We have to hold onto the reality that professionals are in people’s lives because they have a service to deliver. This is just as true for workers involved in promoting social inclusion as any others. The difference – and the element that highlights these issues – is that these workers are using their knowledge of the community, and perhaps their own relationships, as their tools.

L’Arche address this aspect by creating a set of arrangements for what to do when a support worker introduces one of their friends to the person. They insist that this encounter must be initially chaperoned by a third person whose role is to provide

support to the person and to ensure that the contact is welcomed by the service user.

Pope and Keith-Spiegel (2008) remind us that there is an inevitable relationship between what happens inside the therapy room and outside it, with each influencing the other. As they leave behind the paraphernalia of the service building and merge into the community, the risk increases that they will be viewed as acquaintances, friends or possible partners. Their activities appear increasingly indistinguishable from those of a good friend, and so it becomes increasingly important for them to manage expectations and use other means to reinforce their role. At its heart, the relationship remains professional, is focused upon accomplishing identified goals with the person and is persistently helpful so that any signs of harm are rigorously identified and eliminated.

Why doesn't the traditional position work?

There are a number of reasons why we have to question the practicality and validity of the traditional approach of rigid boundaries, slippery slopes and zero tolerance. These reasons include:

- Whilst some therapeutic relationships occur in an 'hermetically sealed' counselling room and fit the single strand BME model, most occur in a more complex and overlapping world. Nurses on a psychiatric ward have formal, individual sessions with inpatients, informal but purposeful conversations throughout the day, informal banter as they pass on the corridor, off-duty encounters as they meet one another's families around the shops, and sightings as they drive or use social venues.
- Multi-strand relationships are more common in settled, close-knit, rural, minority and interest-group communities where network density is high (Syme 2003), such as the Jewish Welfare Board or the emerging discipline of Parish Nursing. The extensive literature on pastoral counselling discusses the work of counsellors who belong to the same faith community as the people they support and therefore a form of dual relationship is the norm, rather than the exception. Similarly, rural social work is beginning to grapple with effective ways to navigate dual relationships (Brownlee et al 2018). Other features of the community within which the relationship is conducted will also affect its meaning. For example, if a friendship between an unemployed person on a low income and a wealthy professional is extraordinary, then it is likely to be imbued with more meaning and significance than if it were commonplace.

- People prefer dual relationships as part of service user involvement, empowerment and choice. As Doel et al (2009, section 4.1.iv) say

> *"As Lord Nelson et al (2004) discovered in their study of families with children in special education, it is highly likely that service users themselves have a preference for practitioners who are flexible with the boundaries. The families in this study appreciated reliable and flexible availability and accessibility, broad responsibility that went beyond a strict interpretation of the professional's role, and dual relationships (i.e. fostering friendships, etc)."*

- The model does not yet acknowledge some other key variables, such as a power differential which may reduce the capacity of the person to be an active partner in negotiating boundaries. Relative power may increase because the person is in a comparatively powerless situation in the service; the person has multiple strands of relationship with the worker, each of which is characterised by inequality; the relationship is of long duration or guards access to resources. The greater the worker's relative power, the more safeguards are needed in terms of stringent regulation and oversight. Of course, where the service user draws on a personal budget to employ their worker, then a dual relationship is instantly formed in which power inequalities occur in both directions. This is perhaps more similar to the American situation where citizens are much more likely to privately engage a worker and pay a fee, or much of the British care sector where people are self-funders.

- The person's current vulnerability, capacity to understand boundaries, and their resources to maintain them may influence the decision about whether to retain the single strand relationship or move into the more complex world of multi-strand relating. Working with people who experience difficulties in conducting relationships (people with a personality disorder or offenders, for example) may increase the need for boundary maintenance by staff. Evidence suggests that people with mental health problems (in particular, women, and former victims of abuse) are especially vulnerable in relation to sexual boundary transgressions (CHRE 2008b).

#16: Is anyone in your team part of, or working with, someone who is part of a close-knit community? How does this affect personal boundaries?

#18: Do your arrangements allow for flexibility in response to individual circumstances?

- The person's place on their recovery journey, as some procedure writers have indicated that the rules should change for inpatient areas or after discharge. Some professional policy documents set relationships on a timeline and so recognise that the worker/consumer relationship has a beginning and an end. Again, the sharpest example of sexual relationship is cited, and some bodies dictate a lifetime ban on such relationships with former patients, while others prefer time-limited prohibitions or a case-by-case approach. Freud and Krug (2002) note that some guidance prohibits dual relationships with former clients, as if the power of the worker persists over years. They say that this is exaggerated and infantilised clients. Moreover, if it is true, then this is excessive power and should be reduced, rather than accepted as fixed and inevitable. Reamer (2003) recommends that a social worker who is contemplating a possible friendship with a former client should consider the person's history, amount of time since the termination of the professional relationship, the person's mental competence and emotional stability, the issues addressed in the professional relationship, the nature, duration and intensity of the professional relationship, the circumstances of the termination, the amount of influence the worker had in the client's life, available, reasonable alternatives, the potential for harm to the client or others and any statements or actions made by the worker during the course of the work suggesting or inviting the possibility of a post-termination friendship, romantic or sexual relationship with the person (Freud and Krug 2002, Reamer 2003).

#17: Does your policy recognise differences in staff role, power differentials, personal capacity, recovery, in work and out-of-work responsibilities?

- The role, identity, training, experience and theoretical orientation of the worker might also affect the way in which relationships are managed, as one might expect differences between appropriate behaviour in relation to the community for a therapist and a jobcoach (or, for that matter, a dentist or a car mechanic). Male counsellors have been found to approve of and engage in multiple relationships more than their female counterparts (Borys and Pope 1989). There appears to be a link between boundary violation between trainers and trainees, and subsequent ethical violation by those trainees later in their careers (Pope, 1979), suggesting that in this area as well as others, socialisation has an impact. Regulatory bodies have sometimes homogenised the whole gamut of relationships that might occur in a service and applied a standard rule, for example, that any employee of the adult social care service

may not spend leisure time with anyone using the service. This ignores the fact that cleaners and finance directors have little direct therapeutic input, like clinical staff from other teams, while they have considerable potential for contributing to social capital and community. Such an approach also, as Fisher and Goldsmith (1999) put it, ‘perpetuates the view of recipients of services as infantile, totally vulnerable, and incompetent to make sound decisions about who they socialise with, do business with, or even fall in love with.’

- The distinction between in-work and off-duty obligations. Within worktime, even the most informal and light-hearted moments must be guided by the therapeutic goal. Off duty, staff continue to have a duty of care as citizens and a duty to uphold the reputation of their professional body and employer, but their free time is just that – unencumbered by expectations and obligations to anyone else. Free to avoid engagements, but free also to engage?

  During a training day on professional boundaries run in Leeds by SITRA, staff were advised that if a person using services entered a social environment in which they were enjoying some off-duty leisure time, they should immediately leave; get off the bus and wait for the next one; abandon their half-filled shopping trolley; walk out of the church service or concert. This contrasts with the OMH (2002) policy that requires staff to exhibit compassion, respect and courtesy. The reach of professional bodies does extend beyond working time, and members have been disciplined for their conduct when not at work [refs[10]].

  L’Arche extend the reach of management processes into off-duty time, requiring support workers to seek permission from their line manager before any off-duty contact with the person, as well as conducting a full risk assessment, building the contact into the support plan and recording outcomes. Their employer’s liability insurance covers these off-duty contacts, on-call frontline support and management assistance is arranged to be available throughout the time of the off-duty contact, and the process is scrutinised by external inspection bodies.

One attempt

OMH (2002) have blended a number of these features into a policy statement that is summarised in the table below.

Behaviour	Inpatient	Community	Discharged

Behaviour	Inpatient	Community	Discharged
Close personal relationship	Prohibited. Prior relationships must be reported and employee should not be part of treatment team	Prohibited if patient is under the age of 18. Prohibited with any adult using the particular service where the employee works. Prior relationships must be reported and employee should not be part of treatment team	Prohibited if patient is under 18. Other contact is discouraged.
Commercial advantage	Prohibited	Prohibited	Prohibited
Commercial relationship	Prohibited. Prior relationships must be reported	Prohibited. Prior relationships must be reported	Living with employee or in a residential unit run by an employee is prohibited. Becoming a private patient of an employee is prohibited until 6 months have elapsed post discharge.
Sexual behaviour or contact	Prohibited. Prior relationships must be reported and employee should not be part of treatment team.	Prohibited if the patient is under the age of 18. Prohibited with any adult using the particular service where the employee works. Prior relationships must be reported	Prohibited if patient is under 18. Other contact is discouraged.
Visiting staff or patient's home	Prior permission needed	Prior permission needed	No restrictions
Attending social settings together that are not part of the treatment plan	Prohibited – disclose all unplanned interactions	Prohibited – disclose all unplanned interactions	No restrictions
Offering or receiving gifts	Prohibited	Prohibited	No restrictions
Corresponding with patients	Prohibited	Prohibited	Prior permission needed

Whilst this document helpfully addresses the reality of multistrand relationships and explicitly notes that 'sensible efforts to reintegrate patients into their communities... are not intended to be construed as exploitative' the tone remains that community connections are grudgingly acknowledged as inevitable, rather than actively welcomed and endorsed as a desirable feature of an effective service.

So for example, Gottlieb (1993) says that the rule of avoiding dual relationships is aspirational in nature. Younggren (2002) advises workers to 'avoid dual relationships if at all possible'.

The Whole Picture – complexity is the norm

Malone et al (2004) list some examples that illustrate that the demand for single stranded, BME relationships is difficult to maintain in the real world, including:

- A social worker is married to a clergyman and her clients join the congregation.
- A nurse opens a private nursing home and then seeks referrals from her former colleagues
- A recovering care manager discloses very personal information at the only AA meeting in town. People using services also attend this meeting.
- The secretary married a man who had previously used the service
- Two people currently using the service helped a worker to change a flat tyre.

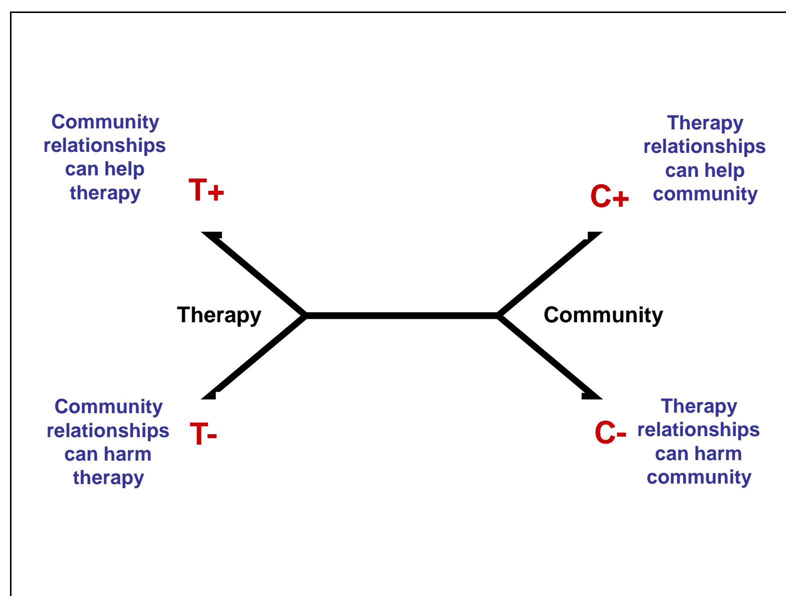
To these, we might add:

- The person uses her Individualised Budget to employ her friend as a personal assistant. As far back as 1981, it was suggested that providing a professional service to a friend may lead to the loss of the friendship (Roll and Millen 1981).
- A person using the service is employed to work in the service and another is invited to contribute to a training event or service development session. One professional body has advised its members that ‘hiring the patient or using the patient as an unpaid volunteer’ is a sign that a therapist or nurse[11] is improperly crossing the therapist-patient boundary (RCP Policy 1.45 paragraph 5.5).
- Personal authenticity means that professionals often choose to volunteer beyond their contract of employment, so teachers may run a youth group, therapists may do some sessions in a community counselling centre and development workers may sit on the management board of a charity. For example, Rufus May facilitates ‘hearing voices’ groups at work and goes off duty and runs a pub open session on emotional healing for members of the public.
- The mental health organisation has a substantial proportion of its staff who have lived experience of mental ill-health.
- People using the service and staff adopt co-production approaches to create a social enterprise, or to use community empowerment and advocacy approaches to identify and solve social problems. As Freud and Krug (2002) say, ‘interactions with clients who are also colleagues collaborating in a

common effort cannot be regulated by dual relationship rules.' In contrast, the RCP has advised that 'joining with a patient in an investment or business venture' is boundary violation (Policy 1.45 para 5.5).

- An NHS Foundation Trust recruits many of its staff and patients as members, in line with policy guidance, but consequently forming a dual relationship.

In order to think through the full map of options, we need to consider each of the four corners of the following diagram. From a conceptual point of view, the bulk of the literature focuses upon the potential harm that other strands of relationship can cause to the therapeutic work. This is only one quarter of the field of inquiry, since they might also contribute benefit to the therapeutic relationship and a full picture needs to consider community relationships, and the potential for the therapeutic relationship to both harm and benefit them. This can be represented in the following polarity map.



Community relationships can harm therapy

Therapy undertaken in the context of multi-strand relationships might be less effective[12]. This may be because they impair the therapist's judgement (COT 2005 para 4.1.2) and objectivity by contaminating transference processes (Langs 1976) and they create a conflict of interests (Montgomery & DeBell 1997) in which, for example, a worker may discharge the patient in order to commence a sexual

relationship with the person (CHRE 2008b). It is for this reason that some doctors do not treat close family or friends. Multi-strand relationships are highly inadvisable in some circumstances and we need to be clear what they are and so know when to close down such a relationship in a respectful way.

Therapy undertaken in the context of multi-strand relationships might be less safe and may be actively harmful. There is more potential, it is argued, to exploit people either wilfully or accidentally harm them, due to the effects of the slippery slope (Ochroch 1987, Russell 1993, Pope & Vasquez 1998). In addition, multi-strand relationships concentrate knowledge and power as the same worker holds the key to many areas of the person's life. For example, when home care staff are from the same extended family, poor practice is less likely to be challenged or questioned (DH 2008 p 37).

Effective therapy, it is suggested, has a clear beginning, middle, and particularly, end but this is disrupted in multi-strand relationships.

The mystique of the professional tends to leak away somewhat when people know about you prior to the start of the therapy. As the person receiving the service is not bound by confidentiality in the same way as the worker, they may well have heard snippets from your work with other people or seen information about you on the internet. The existence of relationships outside the professional strand may compromise the person's current take up or future access to services.

People may not come forward for help because they do not trust the discretion of the worker and they know the power of gossip in their close community. This may be particularly the case for people in tightly-knit communities, such as some ethnic minority groups or shared-interest groups.

Some social workers[13] have recently reported problems with living 'on the patch' including intrusive requests for information and threats of violence after the worker took unwelcome action. (Mickel 2008). The litigious and procedural focus of some professional bodies can mean that multi-strand relationships are prohibited and so practitioners can feel under threat of censure. Such a cloud of fear is unlikely to foster effective listening or creative problem-solving in staff, and will encourage secrecy rather than self-disclosure in supervision.

Community relationships can help therapy

Multiple relationships may lead to a reduction of power within the service and discrimination outside it as these wider connections inevitably carry some freight and become opportunities for combating discrimination. At it's simplest, if the GP's

patient is also the only plumber in the village, then power is fairly evenly distributed in the relationship, especially when the doctor's do-it-yourself plumbing activities fail! Knowing something of the person's strengths from their community roles will reinforce respect and diminish the tendency to focus on problems as the defining characteristic of the person. The wider networks also foster the bonds of social capital and community as the person increasingly takes their place in co-producing community wellbeing. Tudor (1999) suggests that a capacity to move between various roles promotes equality and mutuality and provides the opportunity to deal with rather than avoid relationship complexity.

Multistrand relationships may increase the efficacy of therapy (Clarkson 1994; Gabriel 2005; Gabriel & Davies 2000; Lazarus & Zur 2002; Hedges 1997; Syme 2003; Tudor 1999; Wosket 1999). It allows the therapist who chooses to do so to extend the space within which the therapy is offered, as some solutions are found in the community, rather than in the therapy room. Doel et al (2009, section 4.1.iv) reinforces the main point here:

> *NASW's code of practice (2000) recognises that dual relationships can be part of sound social work practice (Boland-Prom and Anderson, 2005)*

Knowing the person's context and sharing some common experience aids communication and accelerates the process of building the working alliance between the therapist and the person – although the worker needs to take care not to make assumptions. As Freud and Krug (2002) comment, 'We are not convinced that the informal counselling that goes on while working together in a soup kitchen or mailing letters for a neighbourhood rally is less effective than counselling that goes on behind an office door. The opposite might be true.'

Some counsellors and their clients report that some forms of dual relationship can be a positive experience (Gabriel 2005) and can humanise the relationship (Pugh 2007). It has been suggested that staff turnover is reduced when people have local ties. (Mickel 2008). Writing about a counsellor who moved into a small town, Freud and Krug (2002) observe, 'some new clients have sought her out because they feel they know something of her outlook and her values'.

Information gleaned (whether solicited or not) from other strands of the relationship could help to keep people safe and community members can report suspected abuse (DH 2008). For example, the school gate conversation might warn me that my child's new teacher has favourites or endorse the parish priest's ministry as she is known to live with integrity. The technical expertise of a country doctor is not affected by the fact that she lives next door, while her longstanding good reputation in the community (generated by a series of personal disclosures) is comforting when

I am sick. If the person is abused, then relatives or friends can help them recognise that abuse has taken place and get help.

Recent research on hate crimes against people with disabilities makes a very powerful plea for community empowerment to have a safeguarding focus integrated within it.

Therapy relationships can harm community

It is hard for some people to unwind in a leisure space if it is occupied by people from work (Mickel 2008).

The worker may be vulnerable in their personal life. If they address uncomfortable topics or deliver an unwanted intervention (such as detention under the Mental Health Act – although we note that some people who are detained against their will are grateful later on that this action has been taken), then this may cause the person some distress, who may deliberately or inadvertently punish the worker by tarnishing their reputation through other strands of the relationship (BACP 2004, Syme 2003). Where the worker's standing in that community is both treasured and perceived as fragile, this can leave them feeling vulnerable. Those who advocate on behalf of unpopular people may find that their own social position becomes a reflection of the status of those they seek to help (Pugh 2007). Similarly if it comes out that a social worker had been working with a local child sex offender, then neighbours may feel aggrieved that the worker was able to afford her own children some protection that was denied to the rest of the community.

Third parties may advocate on behalf of the person by offering advice, criticisms or suggestions to the worker who will be unable to respond, but may feel that her contact with the third party is thereby affected adversely. Where a therapist engages in a dual relationship with a client, third parties may be harmed, as where students begin to mistrust their tutor's marking decisions because of what is seen as a special relationship with a favoured student (Burian and Slimp 2000).

The worker/client relationship may damage informal community connections, as when a disabled person uses an Individualised Budget to employ a friend and then the formal contractual relationship changes the quality of the informal friendship.

Therapy relationships can help community

The need to be explicit in the counselling room helps the person to consider how they conduct all kinds of community contacts. "In the first session we talk about how

we should greet one another in a social setting...I always give the person the option to acknowledge me or not.” (Parnham 2007, p48-9).

All social relationships in the community involve boundaries and the counselling relationship is nothing special, as we all know to book an appointment rather than display our corns to the GP we meet at the supermarket. Peter Hart (2015) reinforced the message when he found that young people managed their boundaries with staff in an entirely appropriate manner, without relying on staff to maintain them on their behalf. In occasionally reinforcing the boundaries, staff help people to keep all their boundaries.

Where therapeutic workers are part of a community group their clear boundaries help other community members to be more thoughtful too. ‘One benefit that nursing is bringing to congregational ministry is a higher level of accountability because it is a regulated profession. A parish nurse would not share information with the pastoral care team... without asking for permission from the client to do so... It changes how the team and the congregation relate... as the team also learns to ask for permission to share information.’ (Marks 2008).

When multiple relationships can be anticipated, the therapy room provides a safe place for negotiating how these contacts will be conducted. Each transitional moment when one or more of these connections changes provides a new opportunity for renegotiation.

Knowing that a neighbour has access to a professional can reduce the burden on others and draw them closer to the person.

L’Arche explicitly permits workers over time to introduce their ‘clients’ to their friends – and provides detailed safeguards for this that differentiate such boundary crossings from the proscribed boundary violations that would include any form of emotional abuse or sexual relationship.

People who have been hurt in the past (and this is many or all of the people using health and social care services) may find that their trust in human nature is restored through the positive relationship with the worker.

Pugh (2007) discusses situations where social workers in rural situations acted to correct erroneous community perceptions of a service user. Operating in the space where rumour, fact, confidentiality, gossip, social networks and reputations meet is delicate and sometimes vital work.

The way forward - values

An adequate conceptual framework is needed for understanding the potential hazards and benefits of multi-strand relationships in an inclusive world.

Multi-strand relationships are clearly more difficult than single-strand. They may generate more unplanned and unexpected situations, raise anxiety, demand more sophisticated judgements and so need more time in personal reflection and supervision, especially for inexperienced workers. Commissioning and contracting specifications, inspection standards, codes of conduct, risk management, documentation, training, continuing professional development and supervision frameworks all need to reflect the complex nature of safeguarding in an inclusive context. As Pope and Keith-Spiegel (2008) note, blame culture, overwork and mind-deadening routines can lull us into ethical sleep.

Similarly, Gripton and Valentich (2003) state that workers under significant personal stress are less likely to make good judgements, and thus, in such circumstances, any form of dual relationships should be avoided.

Principles rather than too many prohibitions. There are plenty of prohibitions in the legal framework in the United Kingdom, and staff need to be aware of these and uphold them. For everything else, rigid frameworks simply do not work as well as flexible principles. However...

Staff are accountable. Staff are accountable for their conduct and responsible for maintaining a professional relationship with the people that they support. The NASW (2000) code of ethics places the full burden of demonstrating that the client has not been exploited, coerced or manipulated, intentionally or unintentionally, on the worker. This applies for sexual relationships with former clients, their relatives and friends. Doel et al (2009, section 6.4) comment:

> *Professional boundary violations require effective and decisive action, including preventive measures and training. There is no requirement for Personal Assistants to be trained, CRB checks are not compulsory and their Terms and Conditions are determined by the Direct Payments Recipients.*

The most vulnerable people are entitled to the strongest protection. This means that the general principle of working harder to safeguard people who are particularly vulnerable at certain times or stages or their life or in certain settings may yield additional prohibitions. Thus, for example, the rules curtailing the receiving of gifts may be more stringent in an inpatient setting where the wraparound, if temporary, culture can emphasise an inequality of power between worker and person and therefore increase the chance of exploitation. Furthermore, the provision of interpreting services or therapeutic interventions should not be mingled with a prior sexual relationship and people in this situation should receive their care from another

service, team, or if this is not possible, as in the case of extremely isolated services, from another practitioner.

Promote independence. Where people using services are lonely or in trouble and need friends, companions with whom to spend leisure time and the informal advice of others, then the focus should be upon supporting connections with people who are not paid to be involved with the person. Once staff decide that it is their job to be friends and companions for the person, they have lost their way. A variant on this misunderstanding is for the worker to co-opt their own relatives and friends into the friendship circle of the person, rather than assisting the person to develop their own circle which may slightly overlap with the worker's circle, but is definitely not coterminous with it.

Staff/user relationships may feature as a part of the help that services provide, but the emphasis should be upon the inclusive connections that people make in the community beyond the service. Indeed, as Peternelj-Taylor (2003) advises, the best way for staff to keep their professional relationships focused on the person's needs rather than their own, is for the staff to have a full and rich life outside work that meets their personal needs for acceptance, friendship and intimacy. Indeed, Brodsky's research found that lonely therapists were more likely to be caught up in sexual misconduct with their clients.

The person at the centre. 'For too long, staff have exercised patronising and controlling attitudes about risk. A new policy context demands that staff operate in a new partnership with people where they engage in adult discussion of risk and seek to educate people about, rather than minimise, risk.' (DH 2008, page 25). We anticipate that the 'adult discussion' includes informed consent about the way of managing actual or potential multiple relationships. Similarly, the Equality and Human Rights Commission have asserted that '*promoting greater independence inevitably involves transferring responsibility for identifying and choosing how to address risk to individuals'* (EHRC 2009 p28).

That new partnership should involve both family and community wherever possible.

> *'Family group conferences enable the wider family network and community to come together, to provide high-quality information on options, and to establish a dialogue with the vulnerable older family member at the centre of the discussion. S/he is supported by an advocate of their choice to ensure that their view is central to the process. Family group conferences are sometimes a means of empowering vulnerable adults in domestic violence – and are now starting to be used in adult protection.' (DH 2008 p21)*

Reamer (2003) encourages workers to discuss possible conflicts of interest or boundary issues with the person, plan remedies together and monitor their success. However, we note that the discussion of alternative modes of relationship and boundaries is itself a highly charged and potentially seductive process.

Informed consent is crucial, particularly around how the multi-strand relationship is managed – what the therapy is for, how it will be conducted and how it will end. This should help to achieve clarity and reduce confusion over roles, and to consider how boundaries are to be negotiated. Much of the current guidance seems to be designed to help staff decide on behalf of, rather than with clients and so a big shift is needed to place the person at the centre.

Being treated as part of a group offers some protection. Moves to personalise services and supports lays staff open to the challenge that it is motivated by a desire to exploit rather than assist. Therefore staff can ensure that individual offers are genuinely driven from the person's plan or impartially offered to all.

Staff matter too. Parkes and Jukes (2008) assert that the caring or supporting role should be one where the service user's needs are paramount, but not at the expense of having work practices that are exploitative of the worker. Similarly, if guidance to staff closes off their right or opportunity for a leisure life of their choosing, then this is unacceptable also. Nor should guidance require an employee to set aside their own conscience when they go to work, by being required to do something in support of a client that they would refuse to do otherwise. One might think of a support worker who is vegetarian being asked to support someone in a job at an abattoir, as a memorable, if rather extreme example. Doel et al (2009, section 7.4) link these issues with the strictly limited legal grounds for conscientious objection set out in the *Human Fertilisation and Embryology Act* (2007). Individual health professionals (doctors, nurses or anaesthetists for example) may refuse to participate in an abortion or other designated interventions, but must refer the patient to a colleague[14].

Acknowledge that personal and professional lives overlap. Staff out with their families will meet people using the service with theirs - in the street, at the shops and on the bus. Staff and people using services may find themselves in the same pub, restaurant or interest group and this may result in physical touch (on the crowded tube train or the rugby field), the giving and receiving of small gifts (buying a round of drinks in the pub), or visiting each other's homes (through shared membership of the timebank). Sometimes information is disclosed in a social setting that raises anxieties about safety, and might appropriately spill over into work, just as when a nurse on holiday finds himself offering first aid.

Avoid vague terms. It is unhelpful to use vague terms that are subject to too many interpretations. Prohibiting 'inappropriate personal relationships' (GSCC 2004) without specifying what distinguishes appropriate from inappropriate behaviour is unhelpful.

Context, role and intervention matters. In traditional environments, the layout of a counselling room, staff dress code and even the distance between homes and work can be designed to reduce self-disclosure and the discovery or development of multi-strand relationships. Psychoanalytic treatment approaches are predicated on the need for worker anonymity, while other types of intervention favour disclosure, shared experiences and community settings. Working in the staff member's own home or supporting the person to utilise community amenities increases the likelihood of self-disclosure and multi-strand relationships. Similarly, where interventions are utilised that harness the staff member's personal experience, such as self help, peer support or where staff are recruited partly because they have lived experience of mental ill-health, then it is more likely that such relationships will occur. This offers new opportunities to promote recovery and inclusion, while generating additional challenges for safeguarding against abuse.

Privacy and confidentiality. The person has a right to privacy and to pursue their personal life and relationships without undue surveillance or interference. Workers must keep information they glean in the course of their work confidential. This demands that a worker who learns things in the course of her work should not use that information in pursuance of her out of work personal activities, and vice versa. For instance, a worker may not use the client database to gather email addresses in order to advertise a community fundraiser at her child's school. However, if a person using the service wanted to get involved in community fundraising, then building a plan driven by the person's preferences would be acceptable. On a similar note, the service does not have an automatic right to interrogate employees to uncover any information that they may have gleaned about service users through their own personal lives away from work.

Society's expectations on confidentiality are fluid and may change over time. For example, the Domestic Violence Disclosure Scheme is being piloted in England whereby the traditional confidentiality afforded to perpetrators is being set aside in favour of official warnings to any new partners.

A learning organisation. It will take time for the culture to change and staff to feel safe in providing education and support rather than defensively seeking to minimise all risks. When people are hurt by boundary violations or the denial of opportunity to live an included life, then an apology may help.

The Way forward – organisational arrangements

Self-reflection. The following questions may be helpful in self-reflection.

1. Are there other people using the service in the person's circle who may be affected by this community contact?
2. If the community contact is started, which specific aspects of the intervention will be affected?
3. Do feelings of attraction or antipathy in the community or the therapeutic setting affect the other arena?
4. If the community contact is terminated, what will be the impact upon the therapeutic relationship?
5. Should someone else be involved in the decision-making process?
6. Have you kept secrets or felt that there were things about a client that cannot be shared with other staff?
7. Have you rigorously examined your feelings and thought through the issues?
8. Do the roles clash (e.g. a therapist acts in the interest of the client, while squash players are intensely competitive).

The general rule is the more discretion that is available to the worker, the higher is the need for transparency and accountability.

Staff training. One social worker commented that asking the person met during an off-duty social encounter to wait until you can see them in work time was 'not something I could do' (Mickel 2008). This highlights the need for training and support to ensure that staff are proactive so that they minimise boundary violations, and they identify and repair those that occur, addressing such issues as close to when they occur as possible. The Commission for Healthcare Regulatory Excellence (2008b) has recommended that as psychiatry, general practice and obstetrics have the highest reported incidences of sexual boundary transgressions, they can reasonably be expected to take a lead on the introduction of training. We might add that social work also has an unacceptably high level of sexual boundary transgressions and that other groups should make training a compulsory element of continuing professional development. Training needs highly skilled facilitation (CHRE 2008b).

Whistle-blowing. Staff have a duty to pass on their own concerns about the conduct, attitude and behaviour of colleagues (Public Interest Disclosure Act 2008).

Managers need to ensure that such concerns are not routinely disbelieved (CHRE 2008b). Peternelj-Taylor sees these variations in practice arising as a consequence of the pernicious and seductive pull of helping and so she recommends whistle-blowing, amongst other mechanisms. Whilst mutual regulation by peers is a good way to expose behaviour that is clearly harmful but otherwise hidden, there is a real danger here that encouraging staff to report one's colleagues to the 'Boundary Police' will encourage defensive practice. It can also evoke the primary 'boundary emotion' - shame – that can interfere with clear thinking and rational action, and perhaps lead the supervisor to react with retaliation or persecution (Llewellyn and Gardner 2009).

With the person. The allocation systems in some services are designed either to capitalise upon or minimise areas of common interest. *L'Arche* deliberately matches assistants with people with learning disabilities so they have the best chance of enjoying the same leisure activities and hobbies, sense of humour or strength of curry and so creating both the best possible support relationship and potentially becoming friends. However, there is a fine line between enjoying a shared interest and coercing an impressionable person into taking up the worker's hobby. The Royal College of Psychiatrists (Policy 1.45, para 5.5) says that 'promoting involvement in a social or political cause that the staff member is fond of' is a sign of boundary violation.

Workers need to educate the people they work with on the overlapping boundaries between therapy and community and the risks and opportunities that accompany them, and then monitor how this is played out. This should be based on an understanding of the value of community connections – unlike the service we encountered where a person began a greeting in the street and then cut off with an apology of 'I'm sorry, I'm not supposed to speak to you here.'

As a more productive way forward, proper concerns about safeguarding people from sexual abuse by healthcare staff have led to a recommendation to use a chaperone as a means to enhance safety (CHRE 2008b) and we might consider the possible role of other citizens as informal chaperones.

Seeking Advice. The General Social Care Council (2004) insists staff declare issues that might create conflicts of interest. In some circumstances transferring the work to a colleague may be necessary to resolve the conflict and preserve valuable community relationships.

Supervision. The OMH (2002) policy prohibits inviting patients into the employee's home or visiting them in their home without 'requesting and obtaining prior documented approval from a patient's treatment team'. OMH asserts that, "employees must always be cognizant of the welfare of the patient when interacting with persons who receive mental health services, and should disclose interactions which might be subject to the provisions of this policy directive to the appropriate Facility Ethics Committee to confirm that such interactions are not exploitative, intentionally or unintentionally." CHRE (2008b) advises that 'effective supervision is an important part of the strategy for preventing abuse' and that staff should seek advice from their professional body if they are unsure about whether a proposed course of action is appropriate. As well as reflecting on unplanned incidents, supervision sessions should be used to foresee consequences and seek advance approval for initiatives, and review the success of boundary management work. As mentioned earlier, if the climate of the organisation is focused on fault-finding, then staff will be reluctant to explore their conduct, even in supervision sessions.

Record keeping. Both in-work and relevant out-of-work events need to be recorded and potentially explored with colleagues and the person's right to privacy and a life beyond the service that is free of surveillance by workers balanced with the duty to safeguard. We note that some people are supervised for very short periods while others are rarely out of the line of sight of a worker.

Conclusion

To date, guidance on professional boundaries has ignored the realities and the benefits of community life. Proper concerns to eradicate sexual abuse have spilled over into generalised prohibitions that restrict inclusion work. Guidance materials have condemned 'inappropriate relationships' but given no means of evaluating the whole system impact of complex webs of acquaintance, collaboration and shared citizenship. This paper offers a framework for making such judgements, and thus, for the first time, allows staff to promote safety, support opportunity and facilitate inclusion.

References

Allan, Clare, My brilliant survival guide *The Guardian* 14 January 2009.

BACP (2004) *Ethical Framework for Good Practice in Counselling and Psychotherapy.* Rugby: British Association for Counselling and Psychotherapy.

Bates P & Rooms N (2008) Community Bridge-Building as Inculturation *NADD Bulletin*

Bates P (2008) Connecting with Communities. Module 6 in Forrest S & Bradstreet S (2008) *Realising Recovery learning materials* Scottish Recovery Network and NHS Education for Scotland.

Borys DS & Pope KS, (1989) Dual Relationships Between Therapist and Client: A National Study of Psychologists, Psychiatrists and Social Workers *Professional Psychology: Research and Practice* Vol. 20, No. 5, pp. 283-293.

Brodsky – quoted in Reamer 2003 op cit.

Brownlee, Keith; LeBlanc, Heather; Glenn Halverson, Brazeau James N Brazeau (2018) Exploring self-reflection in dual relationship decision-making *Journal of Social Work,* March. DOI: 10.1177/1468017318766423

Bullivant J, Deighan M, Stoten B & Corbett NA (2008) *Integrated Governance II: Governance Between Organisations* London: Institute of Healthcare Management.

Burian BK & Slimp AC (2000) Social dual-role relationships during internship: A decision-making model. *Professional Psychology: Research and Practice*, Vol 31(3), Jun 2000, 332-338

Clarkson P (1994) In Recognition of Dual Relationships *Transactional Analysis Journal* 24,1:32-8.

Clyde (1992) quoted in Pugh 2007.

College of Registered Nurses of Nova Scotia (2002) – quoted in Parkes & Jukes (2008) op cit.

Commission for Healthcare Regulatory Excellence (2008a) *Clear sexual boundaries between healthcare professionals and patients: guidance for fitness to practise panels London*: CHRE.

Commission for Healthcare Regulatory Excellence (2008b) *Learning about sexual boundaries between healthcare professionals and patients: a report on education and training.* London: CHRE.

Cooper I & Jenkins S (2008) Sexual boundaries between physiotherapists and patients are not perceived clearly: an observational study *Australian Journal of Physiotherapy* Vol 54 pp 275-279.

CSCI (2008) *Safeguarding adults: A study of the effectiveness of arrangements to safeguard adults from abuse* Newcastle: Commission for Social Care Inspection.

Department of Constitutional Affairs *A Guide to the Human Rights Act 1*998. (Third Edition 2006)

Department of Health (2007) *Independence, choice and risk* [incomplete reference]

Department of Health (2008) *Safeguarding adults: A consultation on the review of the 'No Secrets' guidance* London: Department of Health

Disch E & Avery N (2001) Sex in the consulting room, the examining room, and the sacristy : Survivors of sexual abuse by professionals *American journal of orthopsychiatry* 71, 2:204-217.

Doel M, Allmark P, Conway P, Cowburn M, Flynn M, Nelson P & Tod A (2009) *Professional boundaries research report* Centre for Health and Social Care Research, Sheffield Hallam University.

Equality and Human Rights Commission (2009) *From safety net to springboard: A new approach to care and support for all based on equality and human rights.*

Faughey, K (2008) *Evening Gazette* 13 December 2008. http://www.gazettelive.co.uk/news/teesside-news/2008/12/13/dismissed-carer-linda-coote-celebrates-tribunal-win-84229-22468914/ accessed 7 March 2009.

Fischer HR, Houchen BJ & Ferguson-Ramos L (2008) Professional boundaries violations: Case studies from a regulatory perspective *Nursing Administration Quarterly.*

Fisher WA & Goldsmith E (1999) Principles underlying a model policy on relationships between staff and service recipients in a mental health system *Psychiatric Services* 50, 11:1447-1452.

Freud S and Krug S (2002) Beyond the code of ethics, Part II: dual relationships revisited. *Families in Society* Vol 83, number 5/6, pp483-492.

Gabriel L & Davies D (2000) The Management and Ethical Dilemmas Associated with Dual Relationships in C. Neal & D. Davies (Eds.). Pink Therapy, Vol 3: *Issues in Therapy with Lesbian, Gay, Bisexual and Transgendered Clients* Buckingham: Open University Press.

Gabriel L (2005). *Speaking the Unspeakable: The Ethics of Dual Relationships in Counselling and Psychotherapy* London: Routledge.

Galbreath (2005) – quoted in Pugh 2007.

General Social Care Council (2004) *Code of Practice* Available at http://www.gscc.org.uk/codes/Get+copies+of+our+codes/ Accessed 16 Nov 2008.

Gottlieb MC (1993) Avoiding Exploitive Dual Relationships: A Decision-Making Model, Michael C. Gottlieb, *Psychotherapy*, Vol. 30, No. 1, Spring.

Granovetter MS (1973) The strength of weak ties *American Journal of Sociology* 78:1360-80.

Gripton and Valentich (2003) – quoted in Pugh 2007.

Hart, Peter. (2015). Young people negotiating and maintaining boundaries in youth work relationships: findings from an ethnographic study of youth clubs. *Journal of Youth Studies.* 19. 1-16. 10.1080/13676261.2015.1112881.

Hedges LE (1997) In Praise of Dual Relationships in L.E.Hedges,R.Hilton & O.B.Candill (Eds.) *Therapists at Risk: Perils of the Intimacy of the Therapeutic Relationship* Northvale NJ: Jason Aronson.

Henley C Posting to the Choice Forum 2 April 2009.

Kagle JD & Giebelhausen PN (1994) Dual Relationships and Professional Boundaries. Social Work: Journal of the National Association of Social Workers. 39,2:213-19.

Kagle JD & Giebelhausen PN (1994) Dual Relationships and Professional Boundaries, *Social Work* Vol. 39, No. 2, pp. 213-220, March.

Kemp, Jill – posting on the Choice Forum 12 March 2009.

Langs R (1976) The therapeutic relationship and deviations in technique *International Journal of psychoanalytic psychotherapy* 4:106-141.

L'Arche (2008) *Friendship policy: Respecting the boundaries of friendship and the employed role of assistant.* Draft policy dated 29 September 2008.

Lawson, Rob Message on the Choice Forum, 6 March 2009. Rob is at Speaking Up for Action, a self-advocacy group for people with learning disabilities in Sheffield. Tel 01142 727723 email speakingup4action@tiscali.co.uk

Lazarus AA & Zur O (Eds.) (2002). *Dual Relationships and Psychotherapy*, New York: Springer. An adaptation of Chapter 31, pp. 449-462 'How Consensus

Regarding The Prohibition Of Dual Relationships Has Been Contrived' is available at http://www.zurinstitute.com/dualconsensus.html

Llewellyn R (2002) Sanity and Sanctity. The Counsellor and Multiple Relationships in the Church. in AA Lazaurus & O Zur (Eds.) *Dual Relationships in Psychotherapy* New York: Springer Publishing Co.

Malone SB, Reed MR, Norbeck J, Hindsman RL & Knowles FE (2004) Development of a training module on therapeutic boundaries for mental health clinicians and case managers *Lippincott's Case Management* Vol 9, No 4, 197-202.

Marks K, ICHM Ontario Regional Parish Nurse Coordinator. Personal communication 2 November 2008.

McKnight, J (1995) *The careless society: community and its counterfeits* New York: Basic Books.

Mickel A (2008) Do I know you from somewhere? *Community Care* 14 August p 14-15.

Montgomery MJ & DeBell C (1997) Dual Relationships and Pastoral Counselling: Asset or Liability? *Counselling & Values* 42,1:30-40.

NASW 2003 – quoted in Pugh 2007 op cit.

National Association of Social Workers (2000) *Code of ethics of the National Association of Social Workers* Washington DC: Author

NMC (2008) *Code of Conduct* Nursing and Midwifery Council. Available at http://www.nmc-uk.org/aArticle.aspx?ArticleID=3056 accessed 16 Nov 2008.

Ochroch R (1987) Symposium: The Pastor-Psychologist: An unethical dual relationship? Response. *Journal of Pastoral Counselling* 22:17-23.

OMH (2002) *Official Policy Manual, Section PC-527, Employee/Patient Relationships.* State of New York: Office of Mental Health.

Parkes N & Jukes M (2008) Professional boundaries in a person-centred paradigm *British Journal of Nursing* vol 17, no 21, 1358-1364.

Parnham J (2007) paper *Dual Relationships in Pastoral Counselling - The Lived Experience of Professional Counsellors in a Pastoral Setting: A heuristic study.* Dissertation for MSc Therapeutic Counselling, University of Greenwich

Pearson A (2006) Being honest *Nursing Standard* Vol 21, No 3, pp22-23.

Peternelj-Taylor, CA (2003) Exploring boundaries in the nurse-client relationship: Professional roles and responsibilities *Perspectives in psychiatric care* 39,2:55-66.

Pope KS (1979). Sexual intimacy in psychological training: Results and implications of a national survey *American Psychologist,* 34, 682–689.

Pope KS (1991) Dual Relationships in Psychotherapy *Ethics & Behavior* Vol. 1, No. 1, pp. 21-34.

Pope KS & Keith-Spiegel P (2008) A practical approach to boundaries in psychotherapy: making decisions, bypassing blunders, and mending fences *Journal of Clinical Psychology* Volume 64 Issue 5, Pages 638 - 652

Pope KS & Vasquez MJT (1998) *Ethics in Psychotherapy and Counselling: A Practical Guide* (2nd Edn.). San Francisco: Jossey Bass.

Psychopathology committee of the group for the advancement of psychiatry (2001) Reexamination of therapist self-disclosure *Psychiatric Services* 52,11:1489-1493.

Pugh R (2007) Dual relationships: personal and professional boundaries in rural social work *British Journal of Social Work* Vol 37, pp 1405–1423.

Putnam RD (2000) *Bowling Alone: The collapse and revival of American community* New York: Simon & Schuster.

Radden J (2001) Boundary violation ethics: some conceptual clarifications. *J Am Acad Psychiatry Law* 29,3:319-26.

Ramsdell PS & Ramsdell ER (1993) Dual Relationships: Client Perceptions of the Effect of Client-Counselor Relationship on the Therapeutic Process *Clinical-Social Work Journal* Vol. 21, No. 2, pp. 195-212, Summer.

RCP (2008) *Policy 1.45* Royal College of Psychiatrists. Available at http://www.rcpsych.ac.uk/pdf/General%20-%201.45%20Staff%20%20Patient%20Boundaries%20%20Relationships_Ashen%20Hill%20East%20Sussex.pdf accessed 16 Nov 2008.

Reamer FG (2003) Boundary issues in social work: managing dual relationships *Social Work* vol 48, No 1 pp121-133.

Rethink (undated) *Professional Boundaries Workbook version 1.1* West Midlands Regional Management Team.

Roll, S & Millen L (1981) A Guide to Violating an Injunction in Psychotherapy: On Seeing Acquaintances as Patients, *Psychotherapy: Theory, Research and Practice,* Vol. 18, No. 2, Summer.

Russell J (1993) *Out of Bounds: Sexual Exploitation in Counselling and Therapy* London: Sage.

Sheppard, Cate – contribution to the Choice Forum 11 March 2009.

Social Exclusion Unit (2004) *Mental Health and Social Exclusion* London: Office of the Deputy Prime Minister

Sonne, J (2005) Nonsexual Multiple Relationships: A Practical Decision-Making Model For Clinicians *The Independent Practitioner*. Available at http://kspope.com/site/multiple-relationships.php#copy

Spencer L & Pahl R (2006) *Rethinking Friendship: Hidden Solidarities Today* Princeton: Princeton University Press

Spiegel W, Colella T & Lupton P (2003) Sexual feelings in the physician-patient relationship: recommendations for teachers *Medical Education*, 37:839–841

Spiegel W, Colella T & Lupton P (2005) Private or intimate relations between doctor and patient: is zero tolerance warranted? *Journal of Medical Ethics* 31:27-28.

Syme G (2003) *Dual Relationships in Counselling and Psychotherapy* London: Sage.

Syme G (2005) *Speaking the Unspeakable: The Ethics of Dual Relationships in Counselling and Psychotherapy* London: Routledge.

Thornicroft G (2006) *Shunned: discrimination against people with mental illness* Oxford: Oxford University Press

Tudor K (1999) I'm OK, Your're OK – and They're OK : Therapeutic Relationships in Transactional Analysis in C Feltham (Ed.) *Understanding the Counselling Relationship* London: Sage.

Walker and Clark (1999) – quoted in Parkes and Jukes 2008.

Wosket V (1999) *The Therapeutic Use of Self: Counselling Practice, Research and Supervision* London: Routledge.

Younggren JN (2002) *Ethical Decision-making and Dual Relationships*. Available at http://kspope.com/dual/younggren.php

[1] The GSCC is to conduct a review of its policy on professional boundaries.

[2] The campaigning organisation *WITNESS: Against abuse by health & care* workers has no proposals about policy on its website http://www.popan.org.uk/ accessed 16 Nov 2008.

[3] The British Psychological Society Code of Conduct, section 4.2 is the Standard of Avoiding Exploitation and Conflicts of Interest. Psychologists should: (i) Remain aware of the problems that may result from dual or multiple relationships, for example, supervising trainees to whom they are married, teaching students with whom they already have a familial relationship, or providing psychological therapy to a friend. (ii) Avoid forming relationships that may impair professional

objectivity or otherwise lead to exploitation of, or conflicts of interest with, a client. (iii) Clarify for clients and other relevant parties the professional roles currently assumed and conflicts of interest that might potentially arise. (iv) Refrain from abusing professional relationships in order to advance their sexual, personal, financial, or other interests; (v) Recognise that conflicts of interests and inequity of power may still reside after professional relationships are formally terminated, such that professional responsibilities may still apply.

[4] BPS Code of Conduct paragraph 4.3 Standard of Maintaining Personal Boundaries. Psychologists should: (i) Refrain from engaging in any form of sexual or romantic relationship with persons to whom they are providing professional services, or to whom they owe a continuing duty of care, or with whom they have a relationship of trust. This might include a former patient, a student or trainee, or a junior staff member. (ii) Refrain from engaging in harassment and strive to maintain their workplaces free from sexual harassment. (iii) Recognise as harassment any unwelcome verbal or physical behaviour, including sexual advances, when: (a) such conduct interferes with another person's work or creates an intimidating, hostile or offensive working environment; (b) submission to this conduct is made implicitly or explicitly a term or condition of a person's education, employment or access to resources; or (c) submission or rejection of such conduct is used as a basis for decisions affecting a person's education or employment prospects. (iv) Recognise that harassment may consist of a single serious act or multiple persistent or pervasive acts, and that it further includes behaviour that ridicules, disparages, or abuses a person. (v) Make clear to students, supervisees, trainees and employees, as part of their induction, that agreed procedures addressing harassment exist within both the workplace and the Society. (vi) Cultivate an awareness of power structures and tensions within groups or teams.

[5] The College of Occupational Therapists (2005) *Code of Ethics and Professional Conduct* London: College of Occupational Therapists. At http://www.cot.co.uk/members/publications/ethics/pdf/code0605.pdf accessed 1 Dec 2008.

[6] A search of the Healthcare Commission website in 2009 using the term 'professional boundaries' yielded no results.

[7] A search of the Commission for Social Care Inspection website in 2009 using the term 'professional boundaries' yielded no results.

[8] The Council for Healthcare Regulatory Excellence (2008) *Clear sexual boundaries between healthcare professionals and patients: guidance for fitness to practise panels London*: CHRE.

[9] A search of the Skills for Care website in 2009 using the terms 'professional boundary' and 'professional boundaries' produced no results.

[10] This happens with illegal activity outside of work, but also with activity that is legal but perceived as bringing the profession into disrepute.

[11] Curious that here the RCP is not offering guidance concerning its own members' behaviour but rather guiding its members to make judgements about the behaviour of another profession.

[12] According to Parnham, several authors contend that there is no evidence that dual relationships are safe or therapeutic.

[13] More comments at www.communitycare.co.uk/carespace-proximity

[14] http://protectthepope.com/?p=4549