Heading Off Boundary Problems: Clinical Supervision as Risk Management

Robert Walker, M.S.W., L.C.S.W.
James J. Clark, Ph.D., L.C.S.W.

The effective management of risk in clinical practice includes steps to limit harm to clients resulting from ethical violations or professional misconduct. Boundary problems constitute some of the most damaging ethical violations. The authors propose an active use of clinical supervision to anticipate and head off possible ethical violations by intervening when signs of boundary problems appear. The authors encourage a facilitative, Socratic method, rather than directive approaches, to help supervisees maximize their learning about ethical complexities. Building on the idea of a slippery slope, in which seemingly insignificant acts can lead to unethical patterns of behavior, the authors discuss ten cues to potential boundary problems, including strong feelings about a client; extended sessions with clients; gift giving between clinician and client; loans, barter, and sale of goods; clinician self-disclosures; and touching and sex. The authors outline supervisory interventions to be made when the cues are detected. (*Psychiatric Services* 50:1435–1439, 1999)

Mental health professionals deal with the intimate personal matters of their clients, and they enjoy the privilege to practice because their endeavors promote the common good. The benefits of prestige and a special role in society carry a duty to safeguard the welfare of the public. The pledge to protect the public good, reflected in the Hippocratic Oath, exists from antiquity, and it binds the professional to a purpose beyond personal gratification (1,2).

Today the law recognizes this special role by defining a fiduciary relationship between the expert professional and the vulnerable client (3,4). The fiduciary responsibility puts the relationship in an ethical framework that bars the professional from self-dealing and from situations in which his or her personal interest conflicts with the client's (3,5). The professional is prohibited from exploiting a client and must refrain from actions that might be harmful to the client (6). This prohibition implies that minor harm can lead to serious harm (7).

Gutheil and Gabbard (8) have warned of the existence of a "slippery slope," on which unchecked seemingly insignificant acts can catalyze the development of unethical patterns of behavior. More recently, these authors have cautioned against simplistic, literal applications of their ethical warnings about boundary crossings and their relationship to violations (9). Noting the pendulum swing of policy and opinion, they call for a moderated application of boundary concepts to ethical practice, an idea that is consistent with earlier representations of ethical standards (10).

The complexities and varieties of contemporary mental health practice settings make a literal application of ethical standards impractical. Mental health professionals now work in settings ranging from formal institutions, such as psychiatric and general hospitals, outpatient clinics, nonprofit agencies, schools, private- and public-sector workplaces, and prisons, to clients' homes, which may include arrangements for assessment and treatment, intensive case management, family preservation, home health care, employee assistance programming, and hospice care. Because of the complexity of these settings and the nontraditional roles of service providers, the boundary rules governing traditional assessment and treatment are not easily applicable. Unfortunately, this situation results in the absence of clear rules or guidelines.

More important, many clients involved in these less structured treatment modalities are disenfranchised individuals who are at greatest risk for exploitation. Many are low-income minority clients with serious mental and physical disabilities that include deficits in cognition, judgment, self-care, and self-protection.

The promotion of cultural diversity in treatment environments often encourages expansion of traditional professional roles (11). The literature in this area calls for more flexible roles and more out-of-office services carried directly to the client in the client's own environment (12). However, these situations can create even greater power differentials between

Mr. Walker *is assistant professor in the department of psychiatry at the University of Kentucky College of Medicine and the Center on Drug and Alcohol Research at the university, 643 Maxwelton Court, Lexington, Kentucky 40506-0350 (e-mail, jrwalk0@pop.uky.edu).* ***Dr. Clark*** *is associate professor in the College of Social Work at the university.*

provider and client than are generally found in office-based psychotherapy practices. It can be argued that a higher fiduciary duty exists for mental health professionals who serve clients in less structured settings and that the relaxation of traditional roles carries with it an increased responsibility to define practice-specific ethical guidelines to protect the vulnerable client.

In this paper, we propose that agencies or practice directors and clinicians articulate practice-specific guidelines for ethical boundaries and establish supervisory processes to inhibit misconduct through careful scrutiny of early warning signs of boundary problems. We identify ten cues to possible boundary problems and suggest supervisory responses.

Clinical supervision to support ethical practice

Fundamental ethical principles can inform practice, but the complexities of the practice environment suggest that program directors might need to develop ethical guidelines adjusted to local culture, program aims, and the capabilities of providers (13). A clear and reasonably specific set of principles or ethical standards is recommended to guide local practice. The standards should be promulgated to all staff and should be signed by each provider, documenting proof of being informed.

However, developing and distributing ethical guidelines or standards does not go far enough. Clinical supervision can be used to apply general ethical guidelines to the complexities of practice settings and the uniqueness of a particular case (14,15).

Clinical supervision can support practice within ethical boundaries by following four major principles. First, the supervision should be proactive rather than reactive. The supervisor should not wait for calamity to review the supervisee's work. Supervision should be continuous and of varying intensity, based on the clinician's caseload and other characteristics of the practice setting, such as changes in funding, management, or contractual obligations.

Second, the supervision should be sensitive to the supervisee's personal situation. A supervisor should be aware of significant changes in the supervisee's life that might indicate increased vulnerabilities. Recent divorce, severe relationship problems, serious illness, or death of a loved one can leave a clinician emotionally vulnerable. A clinician who has previously practiced without distress can unexpectedly change the manner of relating with clients and create boundary concerns.

Third, the supervisor must pay attention to the details of the supervisee's cases and the interactions between clinician and client. For example, it is not helpful to simply rely on diagnostic labels to explain clinician-client problems. Instead, the supervisor should ask the supervisee to relate the full narrative sequences of clinical encounters. The patterns or themes found in the clinician-client interactions can capture meaningful content for further analysis and examination.

Fourth, the supervisory interaction should incorporate guided exploration rather than cross-examination (16). Although focused investigation can play a role during a crisis, the routine supervisory process will generally discover more useful content through less directive means. We recommend the use of the Socratic method, in which the supervisor asks a series of questions that guide the supervisee to reveal and understand his or her clinical judgments and behaviors and, optimally, develop more appropriate views (17).

Using these four principles, clinical supervision can be an effective process for detecting cues of potential boundary problems and exploring them. Based on the literature and practice, we identify ten cues that suggest possible boundary problems. Each is paired with a recommended supervisory response. Whether a boundary problem is serious or not depends less on what the clinician believes than on the regressive response or other harmful response it evokes from a client. It is also important to note that what might be helpful for one client can prove harmful for another; supervisory responses must be tailored to the specific clinician-client situation.

The cues and responses described below generally proceed from less serious to more serious. However, the order in which they are listed does not reflect an absolute ranking.

Strong feelings about a client. Clinicians may confuse personal caring with professional caring (18). Although such confusion generally occurs with novice clinicians, experienced clinicians are not immune to it. Strong personal feelings about a client can indicate a developing personal relationship. Contemporary community-based programs sometimes encourage a more personal interest in the client as an alternative to institutional, regimented services. The supervisor can guide the clinician to develop warm but professional relationships.

Because strong feelings are not always a problem in themselves, the supervisor should first elicit the source and quality of the clinician's feelings about the client, with the goal of promoting greater insight. Second, the supervisor should survey the intensity of the feelings and contrast the case to others in the clinician's caseload. The supervisor should then ask the clinician to examine these feelings to encourage self-observation and professional discipline.

Extended sessions. The practice of extended sessions often develops from strong feelings about a client. An occasional episode should be little cause for concern. A pattern, especially with particular clients, is a cue to potential boundary problems. Many community-based programs place a high premium on flexible care that prioritizes the client's needs. Supervisors can help determine whether it is the client's or clinician's needs that drive the clinician's actions. Supervisors should also monitor the equity of clinical services to avoid favoritism or neglect.

The supervisor can explore the clinician's reasons for longer sessions with a client as a way of discovering subtle favoritism or other personal bias toward the client. Simply exploring these issues may curb the practice. Explicit instruction to shorten sessions or reassignment of the case may become necessary when this approach fails.

Inappropriate communication during transportation of clients. Contemporary case management pro-

grams often expect certain providers to transport clients to programs and services. In such cases, the case manager should be guided to avoid expressive psychotherapy that might explore deeply personal issues. Case managers bear considerable responsibility for drawing clients into services and for facilitating the client's access to care. When a case manager is spending considerable time with a client in the car, in the home, and in nonoffice settings, it is possible for the client and case manager to blur professional and personal roles.

A client who is enrolled in a welfare-to-work program and who has emotional problems might have difficulty understanding the professional limitations on companion-like case management services if the case manager, acting like a clinician, also delves into the client's emotional problems. The suggested intimacy arising from deeply personal conversation in the privacy of an automobile may tax the boundaries of both client and case manager. Vulnerable clients may be unable to adjust psychologically from the intensity of in-depth counseling sessions to more casual contact in the automobile. Emotionally vulnerable clinicians may experience the same problem when they step into a case manager role and have less structured engagements with clients. This practice is more worrisome when the clinician independently decides to transport a client without program approval.

When such a situation is noted, the supervisor should draw a clear line between case management and intensive psychotherapy practices. Performing both roles with the same client is a risk factor for boundary problems. The supervisor should help the case manager or clinician understand and avoid role confusion.

Off-hours telephone calls to and from clients. Current clinical practices sometimes demand the clinician's ready availability to the client. Some new therapy approaches recommend the clinician's availability for even minor "emergencies," such as in treating patients with borderline personality disorder (19). However, four practices can indicate potential boundary problems in these cases: clinicians' giving clients their personal telephone numbers (rather than the number of an answering service or crisis line), a pattern of initiating calls to clients rather than receiving them (except in serious emergencies or to monitor client safety), frequent or lengthy calls, and a pattern of late-night or weekend calls. These practices involve the clinician's personal space and privacy. Unchecked, such access invites the possibility of increasing levels of intimacy.

When off-hours calls are an issue, the supervisor should explore the clinician's goals for such contacts. Likely areas for inquiry include the clinician's need to be needed or to be considered special by the client. The supervisor should help the clinician achieve more realistic expectations about the clinician's role and appropriate services (20).

We recommend the use of the Socratic method, in which the supervisor asks a series of questions that guide the supervisee to reveal and understand his or her clinical judgments and behaviors.

Inappropriate gift giving between clinician and client. Token gifts of appreciation from clients are not of great concern, and within certain cultures, gift giving is often expected. Supervisors need to be sensitive to the cultural dimensions of gift giving, but they should also pay attention to possible boundary problems.

Three concerns arise with client gift giving—the timing of the gift, such as a birthday or Valentine's Day gift; the gift's monetary value; and its personal specificity. Highly personal gifts, even of modest dollar value, should be cause for supervisory concern. A clinician's acceptance of gifts suggests that the clinician-client relationship has changed. Likewise, gifts from the clinician to the client, except when sanctioned by program guidelines, should prompt a supervisory response.

The supervisor should help the clinician explore the possible meanings of the client's gifts. The supervisor should explore how the clinician's and client's perceptions of their relationship might be changed by the gift, either positively or negatively. When gifts are very personal or expensive, the supervisor should help the clinician understand why accepting them could be harmful to the client. They should also explore ways to return items with minimal disturbance to the clinical relationship. In such situations agency rules should be helpful. The clinician can thank the client for being thoughtful but disclose that ethical codes prohibit accepting gifts. This response helps prevent the client from feeling a personal rejection.

Boundary problems in in-home therapy and home visits. Many community-based programs, particularly for persons with serious mental illness and emotionally disturbed children, use in-home therapies to minimize risk of institutional care. Although many of these therapies focus on psychosocial skills training rather than expressive psychotherapy, they can create opportunities for boundary problems. Home visits that are outside sanctioned treatment should be examined very closely. Frequent visits combined with signs of personal interest in the client should prompt more focused supervisory review.

The supervisor should inquire about the clinician's feelings of special interest in the client. Inquiries may lead to exploration of the clinician's rescuer fantasies. Likewise, the clinician's anxiety or ambiguity should be examined in detail. The supervisor should take steps to reduce contact or transfer a case when there are signs of overinvolvement. The supervisor

should immediately intervene if there is reason to believe that a client or a clinician is being exploited.

Overdoing, overprotecting, and overidentifying. The clinician who overidentifies with a client might experience a need to do things for a client rather than help a client accomplish goals and learn to do things for himself or herself. At first, this behavior may appear relatively harmless or even admirable. However, such signs of enmeshment can suggest overinvolvement with a client and potential boundary problems. A clinician involved in this type of relationship might be unaware that the boundary has been crossed. For example, the clinician might believe that the actions truly benefit the client and that diminished involvement will result in the client's feeling abandoned.

In response, the supervisor should explore how this case differs from others in the clinician's caseload. The clinician's perception of unique circumstances or characteristics should provide opportunity for further discussion and, if necessary, confrontation. Uniqueness is especially troubling when it presents in two forms—the clinician's perception of a unique client circumstance or the clinician's belief that he or she has qualities that are uniquely fitted to the client's needs. In either case, the supervisor should focus on the clinician's distorted thinking and consider whether overinvolvement is the clinician's characteristic way of dealing with other people or the response to a particular type of client. If the clinician cannot adequately respond to such redirection, vigorous supervisory intervention is indicated.

Loans, barter, and sale of goods. Financial interaction between a clinician and client other than payment of fees is a boundary issue. Borrowing or loaning money is not always a profound ethical violation; nonetheless, it certainly warrants detailed evaluation. The use of agency funds available for client emergency needs are not a concern. The transfer of personal money or property to or from the clinician is entirely different. Bartering clinical services for goods or other services is ethically troubling and is certainly cause for supervisory exploration except in practice areas where cultural standards have made this practice more normative (21).

The supervisor should state the ethical limits regarding financial transactions with clients. Clear policies and procedures should be established to provide the clinician with unambiguous guidelines about financial issues with clients. The supervisory stance should be firm and generally inflexible. The risk of exploitation of a client in these matters is great.

Clinician self-disclosures. Clinicians who disclose personal circumstances to clients open the door to boundary problems. Limited and clinically directed disclosures can be helpful, and in certain cultures, they are almost essential. However, disclosure of highly personal information is rarely welcome or justifiable. Clinicians who are vulnerable due to personal losses or substance use may make personal disclosures to remedy their own loneliness. Overly personal disclosures by the clinician can suggest mutuality in the relationship rather than collaboration for treatment purposes.

The diversity in practice settings, cultures, and client populations calls for practice-specific ethical guidelines.

The supervisor should first explore the clinician's rationale for self-disclosure. Next, the supervisor should explore with the clinician the possible dynamics of such disclosures and their potential risks. The clinician should be coached on how to therapeutically redirect a client's requests for inappropriate personal information about the clinician. The supervisor should continue to monitor this issue very closely.

Touching, comforting the client, and sexual contact. Some therapists use touch and hugs in their work. We consider this a high-risk practice for most mental health treatment environments. Although the occasional hug might be therapeutic, the risk of harm contradicts its use. Some children's therapists might hold a different opinion. Some young children may need physical reassurance in the course of clinical work. We recognize this need, but recommend careful monitoring of this practice with children.

In some cultures touch is an essential part of meaningful exchange, and its significance must be taken into consideration. Work with elderly persons represents another important exception—touch can be a critical part of therapeutic engagement with this population. However, as a general practice in most mental health settings, physical contact is high-risk behavior.

One might argue that seasoned clinicians could be granted greater license in this area than those less experienced. Unfortunately, experience does not immunize, and even seasoned clinicians can delude themselves into believing that sexual touching is therapeutic (22). Furthermore, despite the clinician's intentions, even "therapeutic" physical contact may be interpreted as sexual by the client (23,24).

The inequality of power and control in the clinician-client relationship also contributes to distorted perceptions of touch (25). Touch has a tendency to escalate physical response, particularly for clinicians who are as emotionally vulnerable as their clients. Sexual contact with clients is simply unethical and actionable (26-31). Psychiatry and social work have perhaps the clearest proscription against the behavior, including sexual contact with former clients. Although the major mental health professions have defined sexual behavior with current or former clients as unethical, less established professions with less clear licensure and certification standards have less clearly stated policies.

At the beginning of the relationship with a new supervisee, the supervisor should express clear rules or guidelines for physical contact with clients. The supervisor should coach the clinician on ways to show support or comfort that do not require hugging or other forms of touch. The prevalence of sexual abuse histories among mental health clients should be discussed along with the possible ramifications for clinical practice.

Conclusions

Gutheil and Gabbard (8,9) have now described a more gradual application of boundary guidelines than their earlier writings might suggest. We agree and suggest that the diversity in practice settings, cultures, and client populations calls for practice-specific ethical guidelines. Guidelines adjusted to the specific practice area can avoid both the rigid application of generic rules and purely subjective case-by-case decisions. Overly rigid rules can inhibit meaningful practice, while subjective decisions are not tested against the broader ethical consensus.

Not all clinicians are able to arrive at appropriate decisions without the benefit of dialogue with others. In fact, too much independence may be a risk factor. Strict adherence to rigid rules, on the other hand, is simply unrealistic. As an alternative to rigidity or idiosyncratic practices, we argue for the use of effective clinical supervision as a primary tool for managing the risk of boundary problems.

As administrative, educational, and monitoring resources become more scarce and as cases become more complex, the likelihood of boundary problems increases. Boundary crossings and violations may damage clients, clinicians' careers, agencies' reputations, and programs' credibility (32). Programs serving minorities, welfare recipients, persons with severe mental illness, and severely emotionally disturbed children face additional risks with already vulnerable populations. In-home services, case management, and other nontraditional services expose clients and clinicians to informal private settings. Without regular, proactive supervision, clinicians and other providers can easily lapse into boundary problems.

Clinical supervision can offer compassionate and cost-effective risk management by addressing clinical events higher up on the slippery slope. The supervisor who intervenes with a clinician's overuse of the telephone or too frequent use of home visits may prevent a lapse into sexual misconduct with a client. By using the four principles of proactivity, sensitivity, attention to narrative detail, and a commitment to Socratic methods, the supervisor is positioned to intervene successfully. The ten cues offer supervisory guideposts for discussion and inquiry. ♦

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