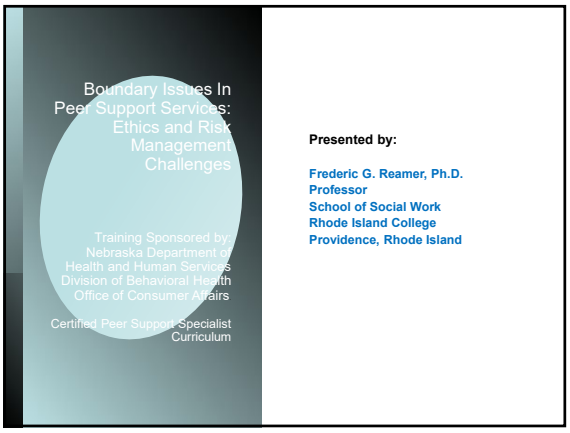
Boundary Issues In Peer Support Services: Ethics and Risk Management Challenges
Training Sponsored by
Nebraska Department of Health and Human Services
Division of Behavioral Health
Office of Consumer Affairs
Certified Peer Support Specialist Curriculum
Presented by:
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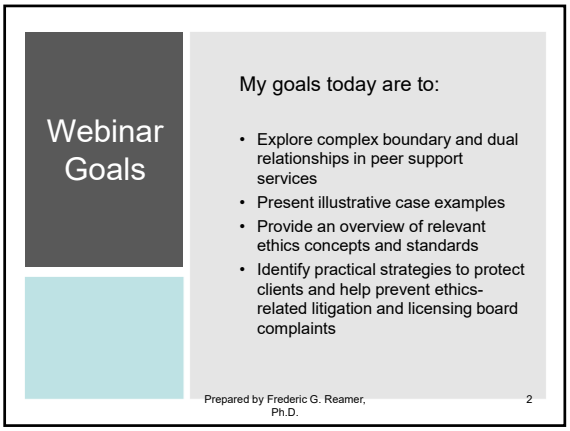
Webinar Goals
My goals today are to:
• Explore complex boundary and dual relationships in peer support services
• Present illustrative case examples
• Provide an overview of relevant ethics concepts and standards
• Identify practical strategies to protect clients and help prevent ethics-related litigation and licensing board complaints
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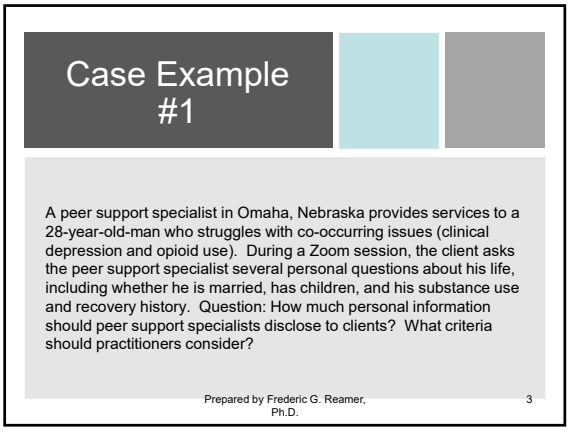
Case Example #1
A peer support specialist in Omaha, Nebraska provides services to a 28-year-old-man who struggles with co-occurring issues (clinical depression and opioid use). During a Zoom session, the client asks the peer support specialist several personal questions about his life, including whether he is married, has children, and his substance use and recovery history. Question: How much personal information should peer support specialists disclose to clients? What criteria should practitioners consider?
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Case Example #2

A peer support specialist is employed in a residential substance use disorders treatment program in Grand Island, Nebraska. One day, the peer support specialist learned that a former acquaintance of his – with whom the practitioner once used, and to whom the practitioner once sold, heroin – was admitted to the program. The peer support specialist was very concerned that his former acquaintance had relapsed. The practitioner logged into the program's electronic health record (EHR) to read the summary of the new client's admission. He also conducted a Facebook and Google search to see what information he could find online. Question: What are the ethical issues? What are your opinions about them?

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Case Example #3

A 32-year-old woman has been in recovery for nearly four years. As an adolescent and young adult, she struggled with severe anxiety symptoms and alcoholism. One day, the woman learned that the substance use disorders treatment program which she completed about four years ago in Lincoln, Nebraska is implementing a new peer support services program and is recruiting personnel. The agency has received a federal grant to fund the program, which includes providing in-depth, comprehensive training to newly hired peer support specialists. The woman is excited by the prospect of working in the program that had been so helpful to her. She calls the director of the new peer support services program to inquire about the job; the director had been the woman's therapist when the woman was a client in the agency's program some years ago. What are the ethical issues? What are your opinions about them?

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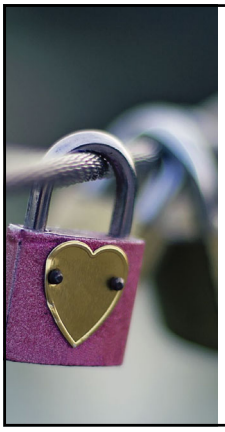

Boundary Issues: The Concept

- Boundary issues occur when practitioners relate to clients in more than one relationship, whether (1) professional, (2) social, or (3) business. Such dual or multiple relationships can occur simultaneously or consecutively.
- A boundary is the edge of appropriate behavior at a given moment in the relationship between a client and therapist, as governed by the therapeutic context and contract. (Gutheil & Brodsky, 2008)
- Dual or multiple relationships are not necessarily unethical; some are, and some are not. It is important to distinguish between:
  - Boundary ***crossings***: acceptable, perhaps inevitable or unavoidable, dual relationships
  - Boundary ***violations***: unacceptable exploitation or conflicts of interest

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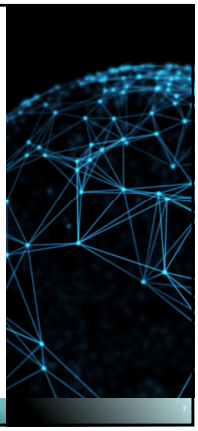
Face-to-Face and Online Boundaries

The emergence of digital technology has introduced a new range of challenging boundary issues associated with the ways in which:

- Practitioners communicate with clients
- Practitioners deliver services
- Practitioners search for information about clients
- Clients search for information about practitioners



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Typology of Boundary Issues: Major Themes

- Intimate relationships
- Emotional and dependency needs
- Personal benefit
- Altruism
- Unavoidable and unanticipated circumstances

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Intimate Relationships

- sexual relationships (current and former clients)
- physical contact
- providing services to former lover
- sexual relationships with clients' relatives or acquaintances
- sexual relationships with supervisees, trainees, students, colleagues
- intimate gestures (e.g., notes, meals, gifts)
- sexualized messages online/social networking

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Emotional and Dependency Needs

- friendships with current/former clients
- community contact with clients (special-interest groups)
- self-disclosure
- unconventional interventions
- affectionate communications
- online relationships: social media and social networking

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Personal Benefit

- monetary gain (e.g., client's will, paid supervision)
- business and financial relationships (loans, investments)
- goods and services (barter)
- advice and services (e.g., client who is physician, nurse, mechanic, stockbroker, childcare)
- favors, gifts, meals, social invitations
- conflicts of interest (e.g., wills, client referrals, selling goods, soliciting clients)
- online social relationships

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Altruism

- giving clients gifts
- offering clients favors
- meeting clients in social or community settings
- accommodating clients (e.g., home telephone, housing, free services, employment)
- self-disclosure to clients (e.g., clinical relationships, self-help groups)
- out-of-office electronic communications (e.g., Facebook, email, text message)

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Unavoidable and Unanticipated Circumstances

- geographical proximity
- cultural, social, ethnic communities
- conflicts of interest (e.g., divorce/custody proceedings, clinicians' family members, students)
- professional encounters
- social encounters (e.g., family events)
- overlapping social network/social media relationships

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The Boundaries of Self-Disclosure

Key considerations:

- The ***content*** of the disclosure
- The ***intimacy*** of the disclosure
- The ***duration*** of the disclosure

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Self-Disclosure: Questions to Consider

- **Why is the PSS sharing this information with the client? Whose needs are being met by the self-disclosure?** Practitioners should carefully examine their motives when sharing personal information with clients. They should consider whether they are disclosing personal information to meet their own needs or their client's needs. Is it purely for the client or is it a subtle, self-serving expression of the practitioner's need to share?
- **What are the potential benefits to the client?** In what ways does the practitioner expect that the self-disclosure will benefit the client?
- **What are the potential risks to the client?** What is the potential harm to the client if the practitioner shares this personal information?
- **How would a panel of the practitioner's peers view the self-disclosure?** Suppose a client files an ethics complaint or lawsuit alleging unethical self-disclosure and related boundary violations. How would members of a state licensing board, a professional ethics committee, or employment-related colleagues interpret the self-disclosure?
- **If the practitioner shares personal information, how much information should be shared?** Practitioners who decide to share personal information with clients should consider sharing relatively superficial, general information that would apply to virtually everyone.
- **Should the practitioner process the self-disclosure with the client?** If practitioners decide to share personal information with clients judiciously, they should consider explaining their rationale and acknowledging directly with the client that the self-disclosure is a deliberate decision. Such discussion can provide clients with a valuable message about maintaining clear boundaries.

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Sexual Misconduct

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- National estimates:
  - Male practitioner/female client = 80%
  - Female practitioner/female client = 13%
  - Male practitioner/male client = 5%
  - Female practitioner/male client = 2%
- Types of misconduct:
  - overt sexual behavior (e.g., sexual intercourse, oral sex, fondling the genital area, touching breasts, genital exposure, kissing)
  - touching behavior (e.g., touching body parts such as shoulders, arms, hands, legs, knees, face, hair, neck)
  - suggestive behavior (e.g., sexual humor, suggestive remarks or glances)

[see: Gutheil & Brodsky, 2008; Reamer, 2015, 2021; Stake & Oliver, 1991]

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Possible Causes of Sexual Misconduct

- client's clinical issues
- type of treatment
- strength of therapeutic alliance
- professional's personality

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Typology of Offending Clinicians [Schoener and Gonsiorek]

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- psychotic, severe borderline, manic disorders
- sociopathic and severe narcissistic personality disorders (self-centered exploiters, calculating, deliberate)
- impulse control disorders (including paraphilias)
- chronic neurotic and isolated (excessively needy, depressed, low self-esteem, poor self-confidence)
- situational offenders (marital discord, loss of relationship, professional crisis)
- naive offenders

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Typology of Offending Clinicians [Simon]

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- character disordered (e.g., borderline, narcissistic, antisocial personality disorder)
- sexually disordered (e.g., pedophilia, paraphilia, sexual sadism)
- incompetent therapist (e.g., poor training, persistent blindspots)
- impaired (e.g., alcohol, drugs, mental illness)
- situational reactors (e.g., marital discord, loss of relationship, professional crisis)

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Typology of Offending Clinicians [Simon]

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- Dr. Perfect: client idealizes therapist's attributes
- Dr. Prince: client idealizes therapist romantically, hopes therapist will rescue
- Dr. Good Parent: client experiences therapist as nurturing parent, desires "reparenting"
- Dr. Magical Healer: client regards therapist as savior
- Dr. Beneficent: client regards therapist as devoted caretaker
- Dr. Indispensable: client believes only therapist is able to care
- Dr. Omniscient: client believes therapist knows and understands all

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Natural History of Boundary Violations

- Gradual erosion of therapist neutrality (therapist takes special interest)
- Boundary violation begins "between the chair and the door"
- Socialization of therapy (increased time spent discussing non-therapy issues)
- Therapist disclosure of confidential information about other clients ("special" relationship)
- Therapist self-disclosure begins (e.g., marital, relationship problems)
- Physical contact begins (sexualized touching)
- Therapist gains control over client (increased dependency)
- Extra-therapeutic contacts occur (e.g., lunch, drink)
- Therapy sessions extended in time
- Therapy sessions scheduled for end of day
- Therapist stops billing client
- Dating begins
- Therapist-client sex occurs

[See Simon, 1999]

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Boundary Violations: Consequences for Clients

- destroyed self-esteem
- destructive dependency
- mistrust of therapists
- difficulty in subsequent intimate relationships
- impaired sexual relationships
- sexual confusion
- guilt and self-blame
- suicidal ideation
- substance abuse
- loss of self-confidence
- cognitive impairment
- increased anxiety
- identity disturbances
- mood lability
- anger
- suppressed rage
- depression
- psychosomatic disorders
- rejection
- isolation
- abandonment feelings

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Gifts: Issues to Consider

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- Monetary value of the gift
- Handmade versus purchased gifts
- Characteristics of the client (e.g., child v. adult, culture/ethnicity, clinical profile)
- Type of therapy and intervention (e.g., psychodynamic, cognitive-behavioral, case management)
- Appropriateness of gift (e.g., modest holiday gift v. sexually suggestive)
- Stage of treatment (e.g., initial stages v. termination)
- Red-flags (e.g., extraordinary effort, quid pro quo)

(see Gutheil and Brodsky, 2008; Reamer, 2015, 2021)

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Risk Management Strategy

- Set unambiguous boundaries at the beginning of the professional-client relationship.
- Evaluate possible dual relationship and boundary considering:
  - amount of clinician's power over client
  - duration of relationship
  - conditions surrounding termination
  - client's clinical profile
  - prevailing ethical standards
- Consider whether a dual relationship in any form is warranted or justifiable.
- Is the relationship exploitative?
- Is the relationship likely to harm the client?
- Ask yourself *"For whose benefit?"* (Latin: *Cui bono?*)
- Pay special attention to incompatible roles (e.g., clinician-client, administrator-secretary, supervisor-supervisee, instructor-student)
- In ambiguous circumstances, consult with colleagues, ethical standards, agency policies, regulations, statutes.
- Discuss relevant issues with all relevant parties, especially clients.
- Work under supervision whenever boundary issues are complex and risk is significant.
- If necessary, refer the client to another professional to minimize risk and prevent harm.
- Document key aspects of the decision-making process and consultation.

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Common Warning Signs

- Engaging in idle, non-therapeutically focused conversation
- Arguing or attempting to impose one's views (e.g., politics, philosophy, religion)
- Becoming inappropriately directive about a client's personal choices
- Attempting to impress a client
- Allowing or engaging in inappropriate personal familiarity and disclosures at beginning or end of sessions
- Feeling that one is solely responsible for a client's life
- Feeling that one has allowed a client to take over the management of his or her case
- Selective or omitted documentation of significant interactions, occurrences, or dynamics in treatment
- Reluctance to discuss a case with a consultant or supervisor to avoid disrupting "special" relationship
- Discouraging client from obtaining consultation
- Insisting on secrecy about what goes on in treatment

(see Gutheil & Brodsky, 2008)

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Questions Concerning Relationships with Former Clients

- How much time has passed since termination of the professional-client relationship?
- To what extent is the client mentally competent and emotionally stable?
- What issues were addressed in the professional-client relationship?
- How long did the professional-client relationship last?
- What circumstances surrounded the termination of the professional-client relationship?
- To what extent is there foreseeable harm to the client as a result of the relationship?

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Key Elements of Professional Negligence

- A duty exists
- Evidence of a breach or dereliction of duty
- Evidence of injury or harm
- Evidence of proximate cause or "cause in fact" (uninterrupted causal chain between breach of duty and injury)

[NOTE: In sexual misconduct cases, plaintiff's lawyer may reframe as negligent rather then intentional tort claim because of insurance policy exclusions and limited coverage, i.e., *concurrent proximate cause* (e.g., nonsexual boundary violations, deception, role reversal, use of drugs/alcohol, misdiagnosis, failure to consult or refer, improper termination, abandonment).]

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Standard of Care

"What a *reasonable* and *prudent* professional, with the same or similar training, should have done under the same or similar circumstances."

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Two Views of the Standard of Care

1. ***Substantive*** standard of care
2. ***Procedural*** standard of care

- Obtain collegial consultation
- Consult relevant literature
- Review relevant policies, regulations, laws
- Review relevant codes of ethics
- Review relevant national practice standards
- Obtain legal consultation, if necessary
- Consult an ethics committee, if available
- Document very carefully

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The Importance of Supervision

Key concepts: *Respondeat Superior* and vicarious liability

Key elements:

- Content of supervision
- Frequency of supervision
- Duration of supervision
- Boundaries between supervisor and supervisee

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