"You feel like family..." Professional boundaries and social model aphasia groups

Sue Sherratt
Deborah Hersh

Edith Cowan University
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SUE SHERRATT¹ & DEBORAH HERSH²

¹University of Newcastle, Australia, and ²Edith Cowan University, Australia

Abstract
In this theoretical paper, we argue that the adoption of the social model to aphasia rehabilitation within group settings changes the metaphorical location of the boundaries between clinicians and clients. Despite a growing literature on group work for aphasia and social model applications for people with chronic aphasia, there has been almost no attention paid to how professional boundaries are negotiated. This paper reviews how this issue is dealt with within professional codes of ethics and what is written more broadly on professional boundaries, and then uses a number of real case examples to encourage further discussion and awareness of this important issue in aphasia rehabilitation within group settings.

Keywords: Aphasia, ethical issues, group therapy.

Introduction
People with communication disabilities enter into a therapeutic relationship with their speech-language pathologists from a position of vulnerability. This is not just because of the inherent power differential that exists between health professionals and their clients but also because of the communication difficulties themselves which further compromise clients’ positions. In order to protect clients, and indeed professionals, there are basic guidelines within professional codes of ethics which look broadly at what is and is not acceptable behaviour, including where the professional boundaries lie within the therapeutic relationship. In this paper, we are interested in professional boundaries in speech-language pathology, specifically in relation to working within social model-based groups for people with chronic aphasia. Such groups are increasingly being offered due to a growing recognition of their value in promoting socialization, conversation ability, participation and well-being (Elman, 2007; Pound, Parr, Lindsay, & Woolf, 2000).

The social model, emerging from the politics of the disability movement in the 70s and 80s, has risen to prominence in acquired communication disorders in recent years (Byng & Duchan, 2005; Jordan & Bryan, 2001; Simmons-Mackie, 2000, 2001b). The terminology associated with this approach is confusing and lacking in clarity. We are using the term social model here as a philosophy of working rather than a therapy approach and it encompasses an equalization of the social relations of service delivery, authentic involvement of users, creation of engaging experiences, user control and becoming accountable to users (Byng & Duchan, 2005). Simmons-Mackie (2000) wrote that it promotes “social communication within natural contexts” (p. 162) and that “the role of the speech-language pathologist must expand beyond traditional confines” (p. 184), possibly including advocacy and the removal of barriers to social participation. Social model values have been widely endorsed (Chapey et al., 2001), reflect aspects of the World Health Organization’s vision of health (Cruice, 2008; O’Halloran & Larkins, 2008) and are also found in broad policy changes in health services more generally which encourage greater client involvement in decision-making and person-centred care (Entwistle & Watt, 2006; Leplege et al., 2007). In addition, the social space in the health professional-client relationship has shrunk due to increased client literacy, socio-technological changes and a greater acceptability for clinicians to express their emotions (Buetow, Jutel, & Hoare, 2009).

There is a distinct gap in the speech-language pathology literature about how the realities of working within a social model impact on traditional boundaries between clients and professionals. In this
paper, we review what is written more broadly on professional boundaries as well as illustrate how this literature relates to group work with chronic aphasia. We then consider how this issue is dealt with in speech-language pathology codes of ethics and consider a number of real case examples which should encourage further discussion and awareness of this important issue.

**Professional boundaries**

A number of authors have grappled with defining or clarifying the relationship boundary but even this term is just one of many metaphors which encompass avoiding risk or negotiating a difficult balance, such as “watch your step”, or being aware of the “slippery slope” (Holder & Schenthal, 2007). For example, Sommers-Flanagan, Elliott and Sommers-Flanagan (1998, p. 38) defined the relationship boundary as the “distinction between the expectations and interactions that would be considered appropriate within the relationship and those that would be considered inappropriate within the relationship”. Austin, Bergum, Nuttgens and Peternelj-Taylor (2006, p. 78) wrote that the boundary “delineates the edge of appropriate behaviors”, that it involves issues of power, influence and control but is often “blurred and ambiguous”. These authors pointed out that boundaries will vary with the type of professional relationship, the cultural context, the personalities of those involved and so on. They suggested that the metaphor of the “boundary” to guide ethical relationships between professionals and clients is not always helpful and that it is useful also to consider others. They discussed a *highway* metaphor in which both professional and client need to watch the road carefully, a *bridge* metaphor with its emphasis on connection rather than limitation, and a *territory* metaphor in which the space is owned by neither party but involves ongoing vigilance, self-monitoring and negotiation.

To further clarify thinking and guide behaviour, a variety of boundaries frameworks have been developed. A professional behaviour continuum (ranging from “underinvolved” to “overinvolved” with a central “zone of helpfulness”) is used by the National Council of State Boards of Nursing (1997). A more detailed continuum, proposed by Davidson (2005), provides a visual representation of clinician-client relationships, with “healthy” or “balanced relationships” located in the centre. The two extremes represent “entangled” or “rigid” relationships. Holder and Schenthal (2007) have also presented a teaching tool, the Boundary Formula, to gauge nurses’ insight into variables affecting their boundaries. In a recent paper, Fronek and colleagues (2009b) described their interprofessional training course on professional boundaries offered in Queensland, Australia. They were careful to go beyond risk management issues and to include a focus on values, self-awareness, ethical decision-making, problem solving, linking examples to practice and interprofessional support.

There are a number of important points that emerge from the literature on professional boundaries. A key concern is that of the “slippery slope” (Holder & Schenthal, 2007) that boundary crossings, not themselves harmful, can lead to boundary violations. For example, exchanges of gifts may be considered as warning signs that professional boundaries may be crossed (College of Audiologists and Speech-Language Pathologists of Ontario, 2004) and detailed guidelines on gifts and conflicts of interest are discussed by ASHA (2004). On the other hand, there are also many authors who stress the importance of a warm and trusting relationship as part of the therapeutic alliance. For example, Sheets (2000) wrote that clients may be harmed if their well-intentioned gifts are refused by health professionals that they hold in high esteem; Curtis and Hodge (1994) go further by stating that refusing offers of reciprocity “may be as rejecting as outright stating to the person ‘You have nothing of value to offer this relationship’” (p. 20). Austin et al. (2006) suggested that rigid boundaries contrasted with the “softness of reality” (p. 83) and that it was important to consider the ethical implications of *not* trying to engage or connect with a client. Under-involvement may be considered a boundary violation, just as over-involvement is (Peternelj-Taylor, 2002), including not engaging with the client, not exploring difficulties in sufficient detail and therefore not determining the client’s values, opinions, needs or goals. This could result in a lack of appropriate referrals or timely information, or perhaps not providing therapy which is relevant to the client. In fact, within nursing, one of the greatest areas of complaint is the *absence* of compassion or kindness (Australian Nursing & Midwifery Council, 2008). Lack of involvement or detachment is thought to be abusive or damaging in counselling and psychotherapy (Curtis & Hodge, 1994; Hermansson, 1997; Williams, 1997). Similarly, empathy, which is considered critical to a therapeutic relationship, may involve boundary crossing (Hermansson, 1997) and Sommers-Flanagan et al. (1998) suggested that a boundary break can demonstrate the counsellor or therapist’s humanity, remove his or her unrealistically idealized position, and serve to enhance the therapeutic relationship.

A similar point has been made in relation to the degree to which a therapist discloses personal information. While there may be very sound reasons not to self-disclose, some psychotherapists have stressed humanistic concepts and methods: “therapy involves an authentic encounter between two real individuals” (Korchin, 1976, p. 352). Such an authentic encounter may entail some degree of self-disclosure on the part of the therapist which makes the client feel more equal to, rather than inferior to, the therapist and which is also a pre-requisite for
boundaries occur. Knapp and Slattery (2004) stated needs and the nature of therapy to determine where such as the care setting, community influences, client O'Neill, Waterman, & Webb, 1997). Sheets (2000) pointed out that nurses should consider variables and type of information I would divulge to a client approximating ‘conversation’ can happen. The amount and type of information I would divulge to a client obviously varies from client to client. Some clients clearly prefer the therapist to determine the course of events and feel uncomfortable with asking questions in a conversational manner. In these cases other strategies need to be put in place to foster conversation. (Togher, 2003, p. 77).

In addition to comments in the literature about the balance of over- and under-involvement and the quality of the therapeutic relationship, a number of authors have pointed out that the context within which therapy is conducted can have a fundamental effect on the professional-client relationship (Jones, O’Neill, Waterman, & Webb, 1997). Sheets (2000) pointed out that nurses should consider variables such as the care setting, community influences, client needs and the nature of therapy to determine where boundaries occur. Knapp and Slattery (2004) stated that particular challenges to professional boundaries may occur when services are provided in a different context. Both clients and professionals may have more opportunity to challenge boundaries in certain contexts, particularly in more informal settings such as in a client’s home. Hersh (in press) found evidence of this distinction when she explored how speech-language pathologists talked about their relationships with their clients, particularly towards discharge from aphasia therapy. She found that therapists in clinical settings were quite concerned to maintain a sense of distance and prevent situations of undue dependency on them by clients. For example, one interviewee, Amanda (all names are pseudonyms) would not see her clients socially because it was “not very healthy” and Patricia said “I don’t ever go for meals with them or anything like that”. Ruby, talking about a colleague finding discharging clients difficult, described the dangers of being too socially entangled:

I think this is why this other person didn’t ever get rid of people because she very much became friends with them and had lunch with them and did all sorts of other things and then just couldn’t do it, you know? There was just no way she could get rid of them.

Despite sharing concerns about over-dependency, therapists seeing people in their homes, or for long periods in the community, often had a slightly different perspective to those working in acute or post-acute care. Their relationships were more often described as being like friendships involving a greater depth of exchange about aspects of each other’s lives.

Contextual issues become particularly obvious in small towns and rural settings (Pugh, 2007) where it is highly likely that clients’ lives and professionals’ lives may intersect (Austin et al., 2006; Sommers-Flanagan et al., 1998) and speech-language pathologists may thus perform dual or multiple roles with clients (e.g., therapy, counselling, advocacy). Whilst there are dual relationships that are obviously harmful, some of these complement, enable and enhance the therapist-client relationship (Moleski & Kiselica, 2005). Sensitivity to cultural differences in boundary management also needs to be considered; culture may affect male-female relationships, greetings, touch and personal space, self-disclosure and gift-giving (Grodnin, 2008).

Another theme emerging from the literature is that boundaries in clinician-client relationships may be fluid and dynamic (Frank, 2002). Frank suggested that ethics be considered as a process rather than a substantive, moving from being the imposition of particular boundaries or a set of procedures to taking on the more complicated work of recognizing the multiple interests that exist (Frank, 2004). He described the “ethics of self-creation”, saying “in orienting to boundaries as doctors do, they create themselves in their relations to others” (Frank, 2002,
Codes of Ethics and boundaries

The codes of ethics of various professional associations act as general frameworks of values or principles to guide practitioners. However, as Parsons (2001, p. 1) states, these codes are not “a cookbook to thumb through when you’re looking for the answer to a dilemma”. The Speech Pathology Australia Code of Ethics (Speech Pathology Association of Australia, 2000) simply states that we: “do not exploit relationships with our clients for emotional, sexual or financial gain”. In Communicating Quality 3 (2006), the standards of practice published by the Royal College of Speech and Language Therapists in the United Kingdom, the advice given is that “RCSLT members must not enter into inappropriate or disruptive personal relationships with individuals” (p. 10). Similarly, the American Speech and Hearing Association states that “(i)ndividuals shall not engage in sexual activities with clients or students over whom they exercise professional authority” (American Speech-Language-Hearing Association, 2003).

These broad recommendations leave many unanswered questions, as Peternelj-Taylor and Yonge (2003, p. 58) write:

Guidelines that address every eventuality simply do not exist in practice. Boundary guidelines are not a panacea: they are a recommended course of action to be used in conjunction with knowledge, experience, and clinical judgment.

In an attempt to manage boundaries, healthcare professionals have resorted to creating lists of behaviours felt to illustrate boundary transgressions such as not to reveal too much personal information, not to touch (apart from a handshake) and to avoid dual roles with clients (Peternelj-Taylor & Yonge, 2003). Austin et al. (2006) summarize the commonly accepted advice for disciplines such as medicine, nursing, psychology and social work as to what kinds of behaviours are considered boundary transgressions: satisfaction of personal needs, revealing personal information to clients, entering into commercial transactions, taking clients to lunch, making home visits, employing clients as secretaries and babysitters, accepting massages, giving and receiving gifts, and hugging and kissing clients. They point out that boundary crossings, which are not harmful and may have therapeutic benefits, are quite different to boundary violations which are clearly harmful and exploitative. But they also cite evidence to suggest that boundary crossings may be precursors to violations, and that harm may be difficult to determine (Epstein, 1994). Similarly, Williams (1997, p. 245) stresses the blurry nature of the division between acceptable and unacceptable in psychotherapy: “whether a boundary crossing is perceived as a boundary violation is very much in the eye of the beholder”.

In addition to being viewed as too general, there have been other criticisms of codes of ethics to guide such issues. Within the field of psychotherapy, Lazarus (1994) proposed that ethical guidelines can become transformed into rigid boundaries which undermine clinical effectiveness. He stated that reliance on external constraints stifles clinicians’ careful consideration of each individual situation and that risk-management principles are starting to take priority over humane interventions. Hermansson (1997) suggested that excessive caution about boundaries might encourage practitioners to become rule-bound and simplistic. Within the social work context, Fine and Teram (2009, p. 60) wrote that historically “ethical issues were thought of as relatively clear-cut with the opinions of clients overshadowed by the authority, expertise, and certainty of the helping professional”. In a post-modern world, however, with such values challenged, the complexities of professional ethics have led to more uncertainty and codes have been criticized for being unhelpful, potentially harmful, exclusive and concerned more with professional privilege than with clients’ rights (Fine & Teram, 2009).

Boundaries in the context of the social model and group work

There are many different types of group work and groups may have different purposes; groups may be highly structured and concentrate solely on language/communication (e.g., direct language or constraint-induced language therapy groups), be less structured but still focus on communication (e.g., indirect language treatment or language maintenance groups) or may address wider issues for the person with aphasia and/or their family members, such as psychological needs, social support, advocacy and community participation (Elman, 2007; Kearns & Elman, 2001). Groups may also be short or long-term, may vary depending on the stage of rehabilitation of the groups members (acute, rehabilitation, community), or may strive to address several purposes simultaneously; for example, language stimulation and social support. Groups run for people with chronic aphasia using a social model
tend to focus on “increasing the communicative access of adults to meaningful participation in everyday life” (Kagan, Cohen-Schneider, Sherman, & Podolsky, 2007, p. 211). The principles of egalitarianism, empowerment, and access within the social model of disability translate easily to these groups. The emphasis is on group members involved in social interaction in an authentic and relevant context. These groups aim to improve communication and psychological adjustment, provide socialization and advocacy opportunities, and focus on the consequences of aphasia both for the person as an individual and in relation to their role in society (Elman & Bernstein-Ellis, 1999; Jordan & Bryan, 2001; Simmons-Mackie, 2001a, 2001b; van der Gaag et al., 2005). Importantly, these groups prioritize conversation as the key focus. Everyday conversation can be likened to jazz with both demonstrating creativity and improvisation (Elman, 2004). Conversation work may appear unstructured but the facilitator, often a speech-language pathologist, works to support conversation using a range of supported conversation techniques (Kagan, 1998) and strategies which allow members to contribute despite their aphasia (Ewing, 2007; Shadden, 2007). These groups provide a safe environment for people to express themselves, share their concerns, find and give support, empathize, make new friends, gain confidence and feel valued. They are places where people with aphasia can be viewed as experts in their disorder, can make their own decisions and be seen as partners rather than clients. Groups are particularly valued by people who feel disempowered, whether by the illness or disease itself or by the subsequent discrimination or stigmatization (Reynolds, 2004). The value of groups to people with communication disorders may be profound as they frequently feel excluded from mainstream social activities and groups can provide the experience of inclusion that may be lacking in their daily lives. The resource of “belonging” may be most readily provided by other people with similar difficulties (Cummins & Lau, 2005).

Our brief summary of the literature on boundaries highlights the challenges facing speech-language pathologists working with social model groups for people with chronic aphasia. These are characterized particularly by how to judge appropriate closeness, self-disclosure, multiple relationships, acceptance of appreciation through gifts, and whether to see people outside the groups themselves. In this section, we explain the contextual issues and draw on a small sample of data, collected by the first author during routine quality assurance focus groups of people with aphasia attending social model-based groups organized by a community health service. These data are not meant to be comprehensive but rather serve to illustrate and explore these boundaries.

The social model group setting challenges the traditional professional boundary in a number of ways. First, there is an assumption of, at least some degree, of mutual disclosure. Without this, the conversations, on which the group interactions are based, would be very unnatural. Either the speech-language pathologist would remain outside, or beyond, the conversation or the topics of conversation would need to be carefully controlled. One client in the group showed her appreciation of the fact that information was shared, in this quote about the clinician’s child feeling unwell. For her, it made the conversation real: “. . . you’ve been talking about your little one and we’re all concerned and it’s just normal. It’s normal”. Another aphasia group member reported the group setting as the only place she could truly be herself, despite having an active social life. Groups can be places, particularly when members are longstanding and know each other well, where people can drop facades of coping, and complain openly about aspects that they might not otherwise reveal (Reynolds, 2004). Such opportunities for honesty may also entail self-disclosure from the therapist.

Secondly, the quality of the relationships between clients and clinicians in established social model groups are also fundamentally important. The following quotes, in response to the question “What do you think about your relationship with your group therapists?” illustrate this well:

• . . . you are not just thinking about seeing someone in the door and walk out and say today’s finished.

• . . . you have treated me really like a friend. It’s very comforting . . . the friendship is very nice, thank you.

• . . . the closeness has come from that you do care. You feel like family every time we meet . . . And you care.

It’s more a natural approach, the relationship.

We are equals (reaches out for clinician’s hand).

Reactions such as these are indicators that the group is functioning as a safe place for genuine conversation and friendship, but equally, there is a pressure on clinicians to think through their professional boundaries carefully. An obvious goal of such groups is also to give people a sense of independence and self-reliance and allow them to transition to participation in their communities. Therapists running these groups arguably should not be the only resource for people with aphasia long-term. They often leave groups due to changed circumstances such as a move to another job, maternity leave and so on. Members with aphasia often drift in and out of groups depending on their needs and circumstances so that friendships and acquaintances are made and broken. Despite these considerations, groups often do see close bonds form, particularly when members have attended for years. There is broad recognition that remaining within professional boundaries is
considered difficult in prolonged or long-term relationships (American Nurses Association, 2005). The benefit of long-standing clinical practice is getting to know patients or clients well over a long period of time (College of Audiologists and Speech-Language Pathologists of Ontario, 2004) and speech-language pathologists often work in situations where they have ongoing contact with clients (Jones et al., 1997). During long-term therapy, the professional and client may share times of close contact and of great stress—this process may have a true bonding effect (Williams, 1997).

Thirdly, it is not unusual for both clinicians and clients to have dual or multiple roles within these relationships. For example, a clinician may be conversation partner, group facilitator and therapist or blend different aspects of professional relationships such as therapist and supporter of social integration (Moleski & Kiselica, 2005). Clients may also have more than one relationship with the clinician, for example, as a group member, student educator, volunteer, research participant, committee member or aphasia advocate.

Another consideration in aphasia groups is that conversations are rarely just talk. They also involve multimodality supports: use of gesture and facial expression, drawing, writing, pictures. Members will often bring in personal photographs and biographical portfolios to help the flow of conversation. Therapists are expected to contribute to conversations and not remain detached. Clients with communication disorders may also use touch more frequently than those without a communication disorder. For example, one client with severe aphasia regularly greeted everyone in the group by touching them on their shoulder. Therapists may use touch to help someone regain attention to the activity in the group, or to alert them to something. Since touch can be easily misinterpreted, Peternelj-Taylor and Yonge (2003) suggest that there should always be a therapeutic goal in mind and that it is done consciously.

The following section uses three real case examples to illustrate some of the subtleties of boundaries and their flexibility within the social model group context. The first two, centring on group members with aphasia, are recounted by the first author from her experiences as a group therapist. It is critical to note that the events were initiated and guided by the clients with the clinician responding to their desire to be of help or be helped. It could be argued, and indeed has been the case in 6 years of group therapy, that providing clinicians respond to the client’s wishes (client-centeredness), there is little opportunity for clinicians to breach the client’s own perceived boundaries. These two cases were selected as being typical of situations that may arise in social model group therapy. These particular groups were established over 6 years ago under the auspices of a community stroke team. Based on conversation and the use of strategies, the groups aim to facilitate emotional adjustment to chronic communication difficulties, provide opportunities to acquire, practise and maintain communication strategies and empower clients by encouraging self-advocacy. An expert-expert partnership exists between the clinicians and the clients, and the groups are client-driven. Attendance is free and clients may attend for as many groups as they like, provided they feel that they are still benefiting. Therefore many group members have attended for a number of years (usually for a combination of weekly, fortnightly and monthly meetings) with the same two clinicians. The synthesis of community-based group therapy, longstanding relationships, the nature of aphasia and social model principles have fostered highly cohesive groups. The third case is a speech-language pathologist’s narrative, gathered by the second author as part of a larger project and reported more fully in O’Halloran, Hersh, Laplante-Levesque, and Worrall (in press). We have provided some commentary in italics.

**Sam’s story**

At an aphasia group, the subject of home renovations came up in conversation at various times. On one occasion, the clinician running the group described the progress of the extension work she was doing on her home. This building work involved moving some very large rocks which were proving to be problematic. Sam, a group member, offered to bring heavy equipment that he had from his working days and help her with this job. This was arranged and he visited the clinician’s home and helped to clear the rocks. This became one of the events recounted often in the group and provided Sam with the opportunity to demonstrate that, although he was not able to explain a task verbally, he was still a competent and generous person.

*This story involved the clinician accepting a gift of help. It also entailed the group member visiting the clinician’s home and meeting her family. On the other hand, the act of helping was of great benefit to Sam’s sense of well-being, self-esteem and confidence. Indeed, this act allowed Sam to take a role of “helper” within and outside the group, and allowed some recognition of his pre-stroke life skills (Shadden, 2007). He is now preparing a conference presentation encouraging those with aphasia to help each other.*

**Andrew’s story**

Andrew, a man in his mid-50s and more than 5 years post-stroke, lived alone and was no longer able to work due to his residual aphasia and hemiparesis. He had little family or social contact. As a long-standing member of a social model aphasia group, he had made some friends there, despite being quiet and a little shy. Andrew decided to buy a computer, despite the fact that he had never used
one before. He contacted the aphasia group clinician and visited her home to discuss the purchase. The following week, Andrew and the clinician's husband shopped for an appropriate computer. Andrew, at his own instigation, later asked for help in connecting his laptop to the Internet, involving the clinician's husband once again. For the first time, he felt confident to start writing documents and now uses his computer to email, obtain information for himself and others, and make reservations to attend his first-ever international aphasia conference.

This account also involved contact at the clinician’s home and with the clinician’s husband. This story shows that the relationships and friendships made in the group were sufficiently strong for Andrew to feel that he could ask for advice and assistance despite his shyness and aphasia. His decision to attend the conference not only shows a re-engagement with life and an increased confidence but also participation in new experiences (e.g., air travel) and social interaction.

Tania’s story

I took her home one day from the Group . . . And, erm, I don’t know how it came about. We agreed to go to the [name of hotel] for a drink. And she wanted to pay but I didn’t feel I could let her pay and I could just sort of sneak it in . . . (gasp) She was so angry with me for paying for this drink and she gave me the money back! She practically threw it at me, I think (laughs), and she was very cross . . . but we had a lovely drink.

This quote, from an interview with Tania, a therapist running a conversation group for people with chronic aphasia, is included for several reasons. First, the act of going for a drink is unusual within the bounds of traditional therapeutic relations. Secondly, the disagreement of who should pay was indicative of a mismatch in how this was viewed: the client was keen to demonstrate her independence and equality in the relationship whereas Tania still felt an obligation to her as her therapist: “I didn’t feel I could let her pay . . .” but tries to “sneak it in”. Thirdly, it demonstrates how working in groups can impact on relationships. Later in this interview, Tania explained that seeing her client in a group, over a long period, entailed a different type of relationship to that found in traditional, individual therapy. Tania knew her client well and that she was missing social opportunities. Tania felt she was one of the very few people around who would take her out and could cope with her significant comprehension difficulties and fluent, jargon output. She reported taking this client out a number of times, both whilst working as the group therapist and subsequently. She also reported that her client really appreciated these occasions.

These examples may be considered as boundary crossings in that they involved clinician-client contact external to therapy times and settings (including the clinician’s home), as well as the involvement of the clinician’s family members. We would contend that these events had the therapeutic benefits of empowering and enhancing the confidence of these people with aphasia as well as facilitating greater social participation and independence. These stories only occurred because of a mutual trust that neither party would exploit the other or encroach further. In other settings, with other client groups, and with different individual personalities, these boundary crossings may not be advisable or helpful. They could be examples of crossings which prevent the therapist from pulling back to a safer position (Sommers-Flanagan et al., 1998) or even of the “slippery slope”. However, we suggest that real examples or vignettes are useful for encouraging reflection and awareness of the risks and benefits (Fronke et al., 2009b). If the social model is viewed as a philosophy underpinning our therapy rather than as a therapy approach (as described by Byng & Duchan, 2005), similarly challenging boundary issues may arise in individual therapy with clients with aphasia or indeed, with other communication problems.

We would also suggest that such vignettes provide a basis for hypotheticals drawing on alternative scenarios and settings: how differently might a boundary be drawn when considering therapeutic relationships with clients following brain injury or right hemisphere damage rather than aphasia? What are the boundary issues for clinicians working closely with communicatively disabled children or their parents over long periods (e.g., accepting gifts or birthday party invitations)? How might the level of experience of clinicians affect the way that they view healthcare relationships (see Kenny, Lincoln, Blyth, & Balandin, 2009)?

Discussion and conclusion

By raising the issue of professional boundaries in this paper, we are not claiming to have absolute answers nor are we calling for the indiscriminate loosening of professional boundaries. Ethical problems rarely have unambiguous answers and are often a matter of defining the problem, considering existing guidelines, and using critical reflection and consultation with supervisors and colleagues in order to choose a course of action (Fronke et al., 2009a). Codes of ethics also need to be reviewed in response to the changing demands of national and international healthcare (Kenny et al., 2009). Considering the paucity of literature on boundaries specific to speech-language pathology, our intention has been to show that there are particular contexts for speech-language pathologists, such as social model groups, where boundaries are often crossed even if these crossings are not harmful. These crossings relate to the changing philosophies underpinning such groups, philosophies which challenge traditional professional roles, and which place the client in a position of
partnership rather than that of client. What is important here is to raise awareness, reflection and discussion of such encounters. Without such critical reflection, boundary violations are more likely. Body and McAllister (2009) state that such dilemmas can only be dealt with if clinicians are aware of the potential for them to arise and to then have the opportunity to negotiate with all the stakeholders involved. Martinez (2002) has argued that, rather than avoiding confronting boundary dilemmas, they can be considered as occasions for discovering and understanding the values implicit in professional work. Recently, Holder and Schenthal (2007) suggested that the general lack of boundary theory among nurses and other healthcare providers was due to a lack of time or resources to discuss dilemmas. Education on boundaries should be an integral component of all speech-language pathology and nursing curricula (Kenny et al., 2009; Peternelj-Taylor & Yonge, 2003), as well as in other professions (Fronk et al., 2009b). Clinicians should not cross boundaries on impulse, should have good reasons for a crossing and know that it can withstand peer scrutiny (Sommers-Flanagan et al., 1998). They should have access to peer supervision, consultation and the opportunity and confidence to acknowledge, discuss and examine their feelings in relation to boundary dilemmas in clinical practice in a safe, productive and non-punitive forum (Curtis & Hodge, 1994; Peternelj-Taylor & Yonge, 2003).

People with chronic aphasia, and indeed their families, often talk about their relationship with their therapist as an integral part of their experience of aphasia therapy more generally (Fourie, 2009; Hersh, 2009). It is essential that, if speech-language pathologists are to provide positive therapeutic encounters for their clients, then they need to negotiate carefully the metaphorical location of the boundary in relation to each individual depending on the particular characteristics of that interaction. We would also suggest that, in line with shared decision-making and a sense of partnership, there may be situations where these issues can be discussed openly with clients in the groups or even in individual therapy. For example, groups may find it useful to discuss whether professionals should accept gifts or meet clients outside a clinic situation. Sommers-Flanagan et al. (1998) have suggested that a potential boundary break can be explored with some clients as part of their right to informed consent for their treatment and to client-centred care. It is essential that clients feel that they are in a position to make a decision regarding a potential boundary crossing.

Overall, speech-language pathologists will need to judge how they can provide a caring, person-centred approach (Macleod & McPherson, 2007) without losing sight of their professional role. They will need to place their decisions within the context of their work and recognize that there is good reason to invest time in thinking such issues through. Individually and group work, using a social model philosophy, for people with chronic aphasia or other communication difficulties, provides the potential to relate to clients as partners, to empathize, to share information and time over long periods and to develop quite close relationships. The increasing popularity of this approach means that more clinicians will realize the lack of fit between traditional professional boundaries and those more suited to the underlying philosophy of this type of work. The boundary may shift or may even be crossed at times but the need for vigilance, discussion, awareness, critical reflection and ethical problem solving remains to protect all involved.

References


