Alberta College of
Speech-Language Pathologists
and Audiologists

Guideline:

# Professional Boundaries

## Prevention of Sexual Abuse and Sexual Misconduct

## Therapeutic & Professional Boundaries

## Trauma Informed Service Delivery

September 2024

# Table of Contents

***Guideline**: Provides guidance to regulated members to support them in the clinical application of Standards of Practice.*

# Introduction

The Alberta College of Speech-Language Pathologists and Audiologists (ACSLPA) is the regulatory body for the professions of speech-language pathology and audiology in Alberta. ACSLPA carries out its activities in accordance with provincial legislation to protect and serve the public by regulating and ensuring competent, safe, ethical practice of speech-language pathologists and audiologists.

In addition, under the *Health Professions Act* (HPA) and the changes introduced with Bill 21, regulatory colleges such as ACSLPA are required to implement a series of measures to prevent sexual abuse of and/or sexual misconduct towards patients by regulated members.

This Bill requires that ACSLPA:

- develop Standards of Practice related to sexual abuse and sexual misconduct;
- define who is a patient and set rules regarding sexual relationships between patients and regulated members;
- provide a program of education and training for regulated members to prevent and address sexual abuse of and/or sexual misconduct towards patients by regulated members;
- develop a Patient Relations Program that provides funding for treatment and counselling of victims of sexual abuse of and/or sexual misconduct towards patients by a regulated member;
- must institute severe penalties including:
    - mandatory cancellation of registration and practice permit for any regulated member whose conduct is deemed to be sexual abuse; and/or
    - mandatory suspension of registration and practice permit for any regulated member whose actions are deemed to be sexual misconduct;
- post discipline histories of regulated members for sexual abuse of and/or sexual misconduct towards patients on a public-facing website; and
- provide training for staff, hearing tribunals and council members to prevent and address sexual abuse of and sexual misconduct towards patients by regulated members.

In accordance with the ACSLPA standards of practice on Professional Boundaries and Sexual Abuse, Sexual Misconduct and Female Genital Mutilation, regulated members must maintain appropriate professional boundaries with clients, professional colleagues, students, and others at all times; and protect patients from sexual abuse and sexual misconduct.

The intent of this guideline is to support regulated members in practicing in compliance with the standards of practice with respect to therapeutic relationships and professional boundaries. The guideline is founded upon the following guiding principles:

- ACSLPA believes that the sexual abuse of and/or sexual misconduct towards patients by regulated members is unethical and an abuse of the therapeutic relationship. ***ACSLPA holds a zero-tolerance stance*** towards any abuse or misconduct of this nature by regulated members. Regardless of the patient's conduct and/or consent, it is always the

responsibility of the regulated member to maintain professional boundaries and abstain from engaging in sexual abuse and/or sexual misconduct.

- ACSLPA regulated members are expected to be fully informed of the terms and implications of the *Health Professions Act (HPA)* and the issues related to the avoidance and prevention of sexual abuse and/or sexual misconduct.
- ACSLPA regulated members are accountable for practicing in accordance with the ACSLPA Standards of Practice and Code of Ethics regardless of their role, practice area or practice setting. Breach of the Standards of Practice or Code of Ethics may constitute unprofessional conduct.

## Clarification of Terms Used

It should be noted that throughout this guideline, the more narrowly defined terms of health services and patient are used in reference to sexual abuse and sexual misconduct.

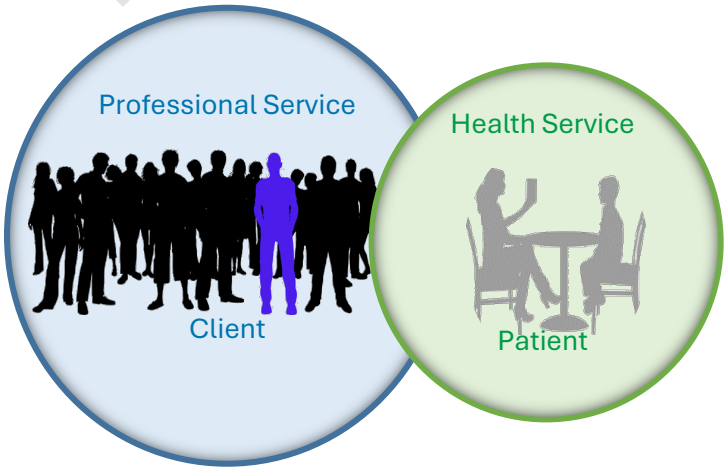
- **Health services**, as defined in the *HPA*, refer to the specific services provided by regulated members in their professional roles as speech-language pathologists and audiologists.
- **Patient**, as defined by ACSLPA, is the direct recipient of the health services provided by the regulated member and does not include others such as their parent, guardian or substitute decision-maker. Patient does not include the regulated member's spouse, adult interdependent partner or other person with whom the regulated member is in an existing sexual relationship if the health service is provided in accordance with the Standards of Practice.

ACSLPA foundational documents, including the Standards of Practice, use broader definitions for the following terms, which are used in reference to professional boundaries and trauma informed services in this guideline:

- **Client** refers to "a recipient of speech-language pathology or audiology services, and may be an individual, family, group, community, or population. An individual client may also be referred to as a patient."
- **Professional services** refer to "any service that comes within the practice of a regulated profession; for the professions of speech-language pathology and audiology, these are as outlined in section 3 of Schedule 28 of the *HPA*."

The relationship of the four terms can be illustrated as follows:

The terms "client' and "professional service" are broadly defined. The common provisions of the *HPA* and ACSLPA standards apply.




The terms "patient" and "health service" apply only to specific activities and individuals. Special mandatory provisions of the *HPA* and ACSLPA standards apply.

## Sexual Abuse and Sexual Misconduct

Sexual abuse of and/or sexual misconduct towards patients by regulated members is considered unprofessional conduct. It can have significant negative impact on patient confidence and well-being and can erode the public's trust of speech-language pathologists and audiologists. It involves an abuse of power on the part of the regulated member resulting in blurring of professional judgment and objectivity, essential to the delivery of patient-centred services. In most cases, sexual abuse and/or sexual misconduct are the result of failing to maintain professional boundaries and not heeding the warning signs of potential boundary crossings.

ACSLPA holds a zero-tolerance stance towards any regulated member who engages in sexual abuse of and/or sexual misconduct towards patients. ACSLPA regulated members must:

- Abstain from conduct, behaviour or remarks directed towards patients that constitute sexual abuse and/or sexual misconduct.
- Not enter into sexual relationships with patients.
- Be cognizant of the circumstances and/or issues that can lead to, or be misinterpreted, as sexual abuse and/or sexual misconduct.

The consequences to the regulated member resulting from a complaint of sexual abuse and/or sexual misconduct are mandatory and severe and include cancellation or suspension of the registration and practice permit.

## Defining Sexual Abuse and Sexual Misconduct

### Sexual Abuse

Sexual abuse, as defined by the *HPA*, "means the threatened, attempted or actual conduct of a regulated member towards a patient that is of a sexual nature and includes any of the following conduct:

i. sexual intercourse between a regulated member and a patient of that regulated member;
ii. genital to genital, genital to anal, oral to genital, or oral to anal contact between a regulated member and a patient of that regulated member;
iii. masturbation of a regulated member by, or in the presence of, a patient of that regulated member;
iv. masturbation of a regulated member's patient by that regulated member;
v. encouraging a regulated member's patient to masturbate in the presence of that regulated member; and
vi. touching of a sexual nature of a patient's genitals, anus, breasts or buttocks by a regulated member."

Sexual abuse applies to a variety of actions that include, not only actual physical touching or intimate behaviour, but also any threats or attempts of a sexual nature.

### Sexual Misconduct

Sexual misconduct, as defined in the *HPA*, "means any incident or repeated incidents of objectionable or unwelcome conduct, behaviour or remarks of a sexual nature by a regulated member towards a patient that the regulated member knows or ought reasonably to know will or would cause offence or humiliation to the patient or adversely affect the patient's health and well-being but does not include sexual abuse."

Sexual misconduct covers a broad spectrum of activities. It is characterized by behaviour or remarks of a sexual nature towards a patient that are unwelcome, unwanted and inappropriate, and that the regulated member ought reasonably to know will offend, humiliate or have an impact on the patient's well-being. Sexual misconduct does not include sexual abuse. Some examples of sexual misconduct
can include:

- Sexually suggestive comments or gestures;
- Inappropriately touching or hugging a patient;
- Commenting inappropriately on a patient's appearance;
- Requesting details of a patient's sexual history that are not relevant for the health service provided by the speech-language pathologist or audiologist; and/or
- Exploiting any real or perceived imbalance of power in a manner that is sexual in nature.

It is the regulated member's responsibility to closely monitor their interactions with patients to ensure that behaviour and comments are always professional and appropriate to the therapeutic relationship. Regardless of a patient's sexual advances and/or consent, it remains inappropriate for a regulated member to engage in a sexual relationship with a patient**.** Sexual abuse of and/or sexual misconduct towards persons other than patients is also deemed inappropriate and may result in the member being investigated for unprofessional conduct.

## Relationships in the Therapeutic Context

Please see Appendix A for examples of potential sexual abuse and sexual misconduct situations.

### Patients

Within the context of the *HPA*, ACSLPA's definition of a patient refers specifically to the individual receiving health services from a regulated member. It does not include the patient's parent, legal guardian, substitute decision-maker, or any other person associated with that individual. A regulated member of ACSLPA abstains from conduct, behaviour, or remarks directed towards a patient that constitutes sexual abuse as defined by the *HPA*.

To demonstrate this standard, the regulated member:

a) must not enter into or have a sexual relationship with a patient, and
b) must not threaten or attempt to have a sexual relationship with a patient.

### Parents, Guardians, and Substitute Decision-Makers of Patients

In addition to refraining from sexual abuse/sexual misconduct with patients, regulated members should avoid any actions of a sexual nature, physical or verbal, with a patient's parent, guardian or substitute decision-maker. Unwelcome sexual comments or gestures to individuals associated with a patient are inappropriate and can erode the trust of the therapeutic relationship. Intimate relationships with these individuals create a conflict-of-interest situation, which can obscure the regulated member's objectivity and judgement in relation to their patient. These types of situations may result in a finding of unprofessional conduct.

### The Regulated Member's Partner or Spouse

Regulated members must be mindful of the fact that providing services to someone with whom they are in an existing sexual relationship may disrupt the trust inherent to the therapeutic relationship and have an impact on the regulated member acting in the patient's best interests.

To avoid the risk of unprofessional conduct, regulated members should, except in particular circumstances, abstain from providing a health service to a spouse, an adult interdependent partner or other person with whom they are in an existing sexual relationship. Particular circumstances include:

- The regulated member provided the health service to the individual in emergency circumstances or in circumstances where the service is minor in nature.
- There is no abuse of power imbalances arising from the health service being provided.
- If further care is required, the regulated member takes reasonable steps, as soon as possible, to transfer care of the individual to another regulated member or regulated health professional.

In the exceptional circumstance that a regulated member is providing health services to their spouse, adult partner, or other person with whom they are in an existing sexual relationship, it is understood that their relationship would fall outside of ACSLPA's standards of practice.

### Former Patients

Former patient means a person to whom one of the following apply:

1) For episodic care[1], no health service has been provided for at least 7 days and there is no expectation of an ongoing professional relationship between the regulated member and
the patient.
2) The patient and/or regulated member has terminated the professional relationship, the termination has been acknowledged by both parties, and at least 30 days has passed since the termination.
3) If neither of the above apply, there has been no health service provided by the regulated member to the patient for one year (365 days).

A regulated member of ACSLPA must abstain from conduct, behaviour, or remarks directed towards former patients that constitute sexual abuse or sexual misconduct, as defined by the *HPA*. The regulated member must not enter into a sexual relationship with a former patient unless:

- There is no ongoing power imbalance between the patient and the speech-language pathologist or audiologist arising from the former professional relationship;
- Sufficient time has passed since the last time health services were provided by the SLP or audiologist, having regard for the nature and extent of the professional relationship between the speech-language pathologist or audiologist and the patient;
- The patient knows and understands that the professional relationship has ended; and
- The patient has consented and is capable of providing consent.

There are significant penalties for sexual abuse and sexual misconduct imposed by the *HPA*. Regulated members must carefully consider whether the person is a former patient before entering into a personal relationship.

## Preventing Sexual Abuse and Sexual Misconduct

Professional boundary crossings usually occur prior to situations of sexual abuse and/or sexual misconduct. It is therefore essential that clear boundaries with patients be established and maintained.

[1] Episodic care means an isolated, short-duration, and minor health service provided to a patient where there is no expectation of continuing care by the regulated member.

In addition to the information already provided in this guideline regarding professional boundaries, the following may be useful considerations to prevent and/or avoid potential situations of sexual abuse and/or sexual misconduct:

- Consider the context of the situation and think before acting or speaking. If in doubt, refrain from any comments or actions that could be misinterpreted.
- Be constantly aware that there are no excuses for inappropriate behaviour of a sexual nature; ignorance, lack of understanding or intention will not absolve the regulated member from allegations of sexual abuse and/or sexual misconduct.
- Identify situations of high potential risk for sexual abuse and/or sexual misconduct and take active measures to maintain professional boundaries.
- Request that the patients bring someone to accompany them to their appointment if either the patient or the regulated member has concerns of possible sexual abuse/sexual misconduct allegations.
- Request a co-worker be present if the regulated member has concerns about safety, and/or inappropriate conduct including that of a sexual nature on the part of the patient.
- Provide the patient with a complete explanation of the procedures to be carried out.
- Exercise additional care to ensure that informed consent is obtained and documented for procedures that patients could misinterpret as sexual in nature such as touching and physical closeness.
- Abstain from making sexual advances or demonstrating conduct of a sexual nature with patients such as offensive jokes, comments or gestures.
- If a patient makes sexual advances or comments/gestures of a sexual nature, refuse to be engaged; explain the ethical and regulatory responsibilities of the therapeutic relationship sensitively.
- Terminate the therapeutic relationship if appropriate professional boundaries cannot be established or maintained and risks of sexual abuse and/or sexual misconduct are increased, transferring the patient's care to another provider if necessary.
- Maintain complete records to document items such as patient's consent, refusal, concerns and reactions; accurate record keeping may prove to be important evidence should there be future claims of sexual abuse and/or sexual misconduct.
- Seek advice from colleagues and/or ACSLPA representatives as required in potential situations of sexual abuse/sexual misconduct.

## Mandatory Duty to Report

As professionals, there are systemic and legal expectations that regulated members hold each other accountable. Reporting potential breaches in conduct is an essential step in enforcing conduct standards and following the *HPA*.

### Self-Reporting

Under the *HPA* section 127.1(1), regulated members are responsible for self-reporting to the Registrar:

- Findings of unprofessional conduct against them with another regulatory body or in another jurisdiction (e.g. another province, territory, country) and must provide the College with the decision;
- Findings of professional negligence against them in a lawsuit; and
- Criminal charges or criminal convictions against them.

### Reporting Other Regulated Members

Under section 127.2(1) of the *HPA*, regulated members must report the conduct of another regulated member to the complaints director if they have reasonable grounds to believe that the conduct of the regulated member constitutes sexual abuse or sexual misconduct, or the procurement or performance of female genital mutilation.

**Exception**: This reporting requirement does not apply if the information was received while providing professional services to another regulated member. For example, if regulated member A received the information while providing professional services to regulated member B, then the reporting requirement does not apply to regulated member A.

### Reporting by Employers

Under section 57(1.1) of the *HPA*, employers must give notice as soon as possible to the complaints director if they have reasonable grounds to believe that the conduct of a regulated member constitutes sexual abuse or sexual misconduct.

## Consequences of Sexual Abuse and Sexual Misconduct

The process for sexual abuse and sexual misconduct follows the complaints process described in the *HPA* with additional protections for the public, including:

- That certain types of resolution and alternative resolution are not available;
- Mandatory minimum penalties after a finding of sexual abuse or sexual misconduct;
- Requirements for at least one member of the Hearing Tribunal to have the same gender identity as the patient;
- Requirements for trauma informed training and sexual violence training for the Hearing Tribunal;
- An opportunity for a complainant of sexual abuse or sexual misconduct to provide an impact statement at the hearing; and
- Mandatory publishing of decisions.

## Responsibilities Under the HPA

Under the terms of the *HPA*, ACSLPA is required to have a number of measures in place to address sexual abuse and sexual misconduct by its regulated members.

### Complaints Process

Patients who feel they have been the subject of sexual abuse or sexual misconduct are encouraged to make a complaint with the ACSLPA Complaints Director. More information related to the processes for dealing with concerns and complaints can be found at acslpa.ca.

### Funding for Treatment and Counselling

As required by the *HPA*, ACSLPA funds patient treatment and/or counselling when there is a complaint involving sexual abuse and sexual misconduct towards a patient by a regulated member.

- The treatment and/or counselling is organized and provided through an independent third-party program.
- Sessions are held in confidence, including from the College.

- Accepting funding for treatment and/or counselling is voluntary. It is the patient or caregiver's responsibility to contact the independent third-party program if they are approved for funding.

A patient's eligibility and approval for funding will end:

- After a period of time, if the maximum amount of funding is reached; or
- When complaint proceedings are finished.

A decision by ACSLPA to provide funding to a patient does not constitute a finding of unprofessional conduct against the investigated person. The two processes are independent.

## Public Facing Register

Because ACSLPA's role is to protect and serve the public interest and not to serve the needs of the regulated members, the College must report certain information about imposed practice permit conditions and hearings on its website, in the Annual Report submitted to the Government of Alberta and kept available on ACSLPA's website, to other Canadian regulatory bodies, and on the General Register.

The College may also share with other SLP/Audiology governing bodies if a regulated member or former member is under investigation or has had complaints. All hearing decisions, notices of hearings or appeals, and some resolutions agreements, as agreed to by the investigated member, are published on ACSLPA's website.

# Professional Boundaries

## Therapeutic Relationships with a Patient

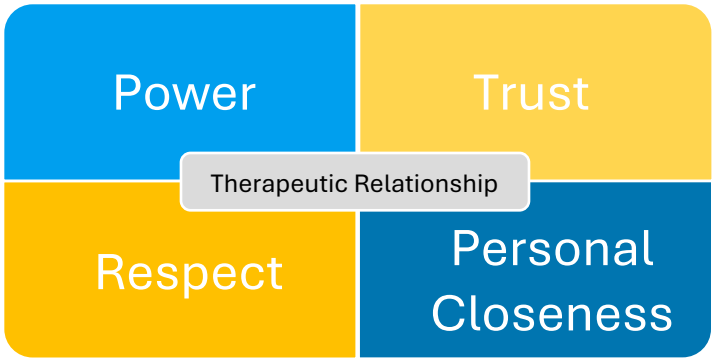
The therapeutic relationship is the professional relationship between a regulated member and a patient. This relationship is different from a personal non-professional relationship, as the regulated member must consider the patient's needs first and foremost, and because there is an expectation that the regulated member will not use the therapeutic relationship for any personal reasons or benefits.

The table below highlights some key differences in the characteristics of therapeutic versus personal relationships.

| Relationship Characteristic | Therapeutic Relationship | Personal Relationship |
|---|---|---|
| Remuneration | Professional receives financial compensation for health services provided to the patient | No payment for being in the relationship |
| Length | Limited to the duration of health service | No limit |
| Location | Limited to health service area/location | No restriction |
| Purpose | To provide health services to the patient | Enjoyment, interest-directed |
| Structure | Organized around the provision of health services (e.g., appointment length, frequency) | Unstructured |
| Power Balance | The professional is in a position of power, being empowered by their professional knowledge and skills, influence, and access to the patient's private information | Shared |

### Key Components of the Therapeutic Relationship

Power, trust, respect, and personal closeness are key components that regulated members must consider when managing the boundaries of a therapeutic relationship. It is extremely difficult to maintain a therapeutic relationship if any of these are violated.



Power: The therapeutic relationship involves an imbalance of power between the regulated member and the patient, whereby greater power is held by the regulated member. This imbalance of power is due to a number of factors:

- The regulated member has greater knowledge, authority and influence in the health system. This includes influence in decisions made about the patient's care.
- The patient is reliant on the regulated member for their care.
- The regulated member has access to personal information about the patient.
- The provision of professional services may involve physical closeness and varying degrees of undress (e.g., bedside evaluations, mother nursing an infant).

As a result, the patient may feel vulnerable and avoid confronting the regulated member or challenging their knowledge or expertise, for fear that the services they need will be compromised or withheld. Patients may also feel vulnerable in a therapeutic relationship because it creates a dependence on the healthcare provider and requires trust that the provider will act in their best interest.

Regulated members must keep this power imbalance in mind and strive to minimize the power imbalance in the therapeutic relationships with patients. This can be accomplished through a patient centered approach, which recognizes the inherent vulnerability of the patient, and creates an environment where the patient feels safe and free to ask questions and is an active participant within the therapeutic relationship.

Trust: The therapeutic relationship between the regulated member and the patient is based on trust. The patient must:

- Trust that the regulated member has the necessary knowledge, skills, and competence to provide quality care;
- Trust that the regulated members will act in the patient's best interest and will do no harm; and
- Trust that the regulated member will not divulge personal information.

If a regulated member does not use their skills and abilities to address the patient's care needs, or otherwise does not act in their best interest, a loss of trust may occur. It is the responsibility of the regulated member to be sensitive to the vulnerability of the patient and take the necessary steps to establish and maintain trust.

Respect: Regulated members must act in a way that is respectful of the patient's participation in their care. Respect for the patient's beliefs, values, and morals is required to develop a therapeutic relationship. The regulated member is not required to adopt or agrees with the patient's views but must accept the patient's perspectives and ensure that their own values and beliefs do not compromise the quality of care that they provide.

Regulated members have an ethical obligation to respect all persons regardless of differences in background, particularly with respect to protected human rights grounds, including gender, race, religion, disability, ancestry, etc. The regulated member must also respect and support the autonomy of the patient by obtaining informed consent for the professional services provided.

Personal Closeness: The context of the therapeutic relationship can include physical closeness, varying degrees of undress, and disclosure of sensitive personal information. While these practices are acceptable when carried out appropriately, they may deepen the patient's feelings of vulnerability. Regulated members must practice sensitivity to protect the trust and respect of the

therapeutic relationship. Regulated members must respect patient autonomy and ensure that patients share control in decisions about their care.

## Professional Boundaries

Professional boundaries are the parameters that define safe therapeutic relationships (between a regulated members providing a health service to patients) and safe professional relationships (between a regulated members providing a professional service to clients). Note that throughout this section on professional boundaries, this guideline uses the broader term 'client' (i.e., any recipient of speech-language pathology or audiology services).

These parameters set limits for these relationships and are based on the recognition of the inherent power imbalance, the vulnerability of the client and the responsibilities of the regulated member in the therapeutic or professional relationship. Professional boundaries help the regulated member and the client recognize the difference between therapeutic and personal relationships and avoid potential misunderstanding of words and actions.

Professional boundaries can be influenced by factors such as the physical environment, the length of time of the therapeutic relationship, and the achievement of certain therapeutic goals. A professional boundary can therefore be a dynamic line which, if crossed, will constitute unprofessional conduct and misuse of power.

Inherent to establishing therapeutic relationships is knowing where to draw the line between a professional relationship and a personal one, and how to avoid crossing that line. To do so, regulated members must acknowledge:

- The power imbalance inherent to the client-provider relationship;
- The expectations for appropriate care; and
- The regulated member's duty of care.

## Establishing Professional Boundaries

- Introducing yourself to the client by name, professional title, and a description of your role in the patient's care.
- Addressing the client by their preferred name and/or title.
- Approaching the therapeutic interaction considering the client as an equal. This includes how you greet the client, how you position yourself during the interaction, and using plain language to explain what you are doing.
- Being attentive to and addressing the client's concerns.
- Validating the client's concerns and individualizing your approach to address their unique needs.
- Obtaining and documenting the client's informed consent to proposed health services, ensuring consent is specifically obtained for procedures that could be misinterpreted (e.g., touching and physical closeness).
- Practicing non-judgemental active listening.
- Being aware of and avoiding comments, attitudes, or behaviours that are not appropriate in a therapeutic relationship or that may cause discomfort (e.g., self-disclosure, sexually suggestive comments/actions, or the expression of inappropriate personal opinions/remarks).
- Adapting your communication strategies to facilitate the client's understanding of proposed services.
- Avoiding practicing outside of professional norms (e.g., outside of typical hours or settings).

- Maintaining an environment that protects the privacy and confidentiality of patient information in all contexts of service delivery.
- Maintaining accurate clinical records.
- Engaging in self-reflection of your interactions with clients.

## Maintaining Professional Boundaries

SLPs and Audiologists need to maintain clear separation between their therapeutic or professional relationships and personal relationships by:

### Practicing Self-Reflection

Self-reflection requires practitioners to give serious thought about their own character and actions. Participating in reflective activities is a necessary first step in gaining self-knowledge.

Examples of professional self-reflection include journalling, meditation, debriefing with a colleague, and/or tracking the frequency of reoccurring emotions and conflicts. Regulated members may also benefit from regularly checking in with themselves to assess if they are operating within therapeutic boundaries as defined in ACSLPA's *Standards of Practice* and *Code of Ethics*.

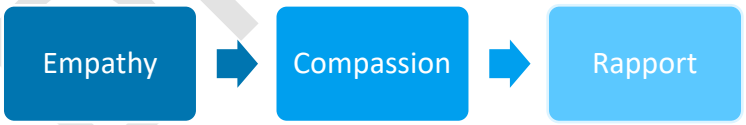
### Gaining Self-Knowledge

Self-knowledge is the understanding a practitioner gains about their own attitudes, behaviors, beliefs, and values because of their participation in self-reflection activities.

Having self-knowledge allows regulated members to engage authentically with their clients and set mutually beneficial, healthy boundaries in their work environment.

### Communicating Empathetically

Empathy, or the ability to understand and share the feelings of another, is the first link in a chain reaction that develops an effective therapeutic relationship.




Empathy allows regulated members to be compassionate in their care, by adapting their approach to respectfully acknowledge and mindfully accommodate the experiences of individual clients. The rapport developed through compassionate communication in turn leads to increases in trust and client participation.

### Understanding Role Limitations

Pressure to breach professional boundaries can happen when regulated members lose sight of the limits of their role as an SLP or Audiologist. Empathy experienced during service provision, such as after disclosures of abuse, may motivate the regulated member to take on duties best suited for a social worker or other professional helper.

Regular self-reflection, self-knowledge, and firm professional boundaries can keep regulated members mindful of their role limitations. Regulated members should be able to recognize when they are at risk of providing professional help that is outside of the scope of practice for their profession, i.e., when support the client requires is outside of their range of their professional

knowledge, skills, and expertise. It is important to acknowledge role limitations with clients, and to inquire if they would like support seeking a referral to a more appropriate provider.

## Boundary Crossing

Boundary crossings are inappropriate behaviours such as feelings, conduct or remarks that compromise and violate the nature of the therapeutic relationship, regardless of who initiates the boundary-crossing interaction. Boundary crossing behaviours may be deliberate and clearly not appropriate, or they may be unplanned and accidental. It is important to note that how the client perceived the behaviour matters, not the intention of the behaviour.

Boundary crossing can result when regulated members confuse their own needs with those of the client, or when regulated members do not recognize their own boundaries or have misunderstood the client's boundaries. Boundary crossings can cause harm even when the client does not recognize the distress that resulted from the crossing.

Some examples of boundary crossing behaviours include:

- Inappropriate verbal and nonverbal behaviours such as retaliation, intimidation, teasing or taunting, swearing, cultural slurs, and inappropriate tones of voice that express impatience or exasperation.
- Disclosure by the regulated member of excessive amounts of personal information.
- A reversal of roles that results in the client supporting the regulated member.

A boundary crossing can have a serious impact on the therapeutic relationship such as:

- Breaking the trust between the regulated member and the client,
- Causing the client or regulated member to make decisions about service provision that are not in the best interests of the client,
- Affecting the regulated member's professional judgement and the services being provided,
- Preventing the client from asking questions and providing voluntary consent, and
- Violating professional standards which may result in unprofessional conduct.

It is the responsibility of the regulated member to frequently assess and manage boundaries in order to maintain the therapeutic relationship. Boundary crossing can be prevented in part by regular self-reflection as regulated members' check-in with their behavioral motivations and realign themselves with the *Standards of Practice* and the *Code of Ethics* as needed. Regulated members may also contact ACSLPA for support, as needed.

### Risk Factors for Boundary Crossing

A number of potential risk factors that may result in boundary crossings by regulated members have been identified including:

- Physical and mental health issues, including stress and burnout,
- Belief that the rules "don't apply to me" or to the situation at hand,
- Lack of knowledge or respect for standards of practice and other professional obligations,
- Working in isolation (either as a sole charge practitioner or due to team dysfunction resulting in isolation),
- Lack of clinical knowledge/experience or failing to maintain currency of knowledge, and/or
- Workload or other system factors.

### Warning Signs of Professional Boundary Crossing

The blurring of boundaries often occurs gradually and unintentionally. However, minor transgressions tend to lead to more significant ones if left unchecked.

It is important to be aware of the warning signs of boundary crossings such as:

- Selecting clients based on appearance, age, or social status.
- Acting defensively, being uncomfortable or making excuses when your relationship with a client is questioned.
- Being hesitant (except for reasons of confidentiality) or embarrassed to discuss the relationship between you and your client.
- Denying the fact that the client is a client.
- Dressing differently when a particular client is booked.
- Offering treatment or attention to a particular client that is different from normal practice (e.g., frequently extending appointments beyond the scheduled time, keeping the client on treatment longer than what is needed, offering appointments in "off" hours, cancelling appointments to fit the client in, extending credit for payment for services).
- Deliberately scheduling client sessions to take place at a time when others are likely to not be present (e.g., early or late appointments), particularly when this has not been requested by the client or is unrelated to therapeutic needs.
- Sharing secrets with a client.
- Selective reporting of client's behavior (positive and negative).
- Doing something unethical or illegal for a particular client (e.g., lending money, providing false receipts, checking the hospital records of a relative of the client).
- Exchanging expensive or personal gifts with a particular client.
- Experiencing feelings of mutual or one-sided attraction to a particular client that are beyond the therapeutic or professional relationship.
- Flirting or responding to personal advances by a client.
- Deliberately meeting socially with a patient.
- Sharing excessive personal information with a client (e.g., personal issues, contact information for non-clinical reasons).
- Providing the client with a home or personal phone number or email address unless it is required in the context of a therapeutic or professional relationship.
- Spending time with a client beyond what is needed to meet their therapeutic needs.
- Assisting a client with something that is outside of the therapeutic or professional relationship.

## Managing Professional Boundaries

It is the regulated member's duty to establish, maintain, and monitor the boundaries of a therapeutic or professional relationship. When the actions of the regulated member fall outside of what is considered typical, or when the regulated member is concerned that they may have crossed a professional boundary, they should reflect on the following questions:

- Who is benefiting from my actions?
- Are my actions in the client's best interest?
- Are my actions something the client needs in order to achieve the agreed upon treatment plan?
- Do my actions affect the professional services I am delivering?
- Will my actions be potentially confusing for the client?

- Will my actions change the client's expectations in any way?
- Are my actions different than what I would do for my other clients?
- Are my behaviours different from those of other practitioners in the same circumstance?
- Am I comfortable recording my actions in the client's record?
- Would I tell a colleague about this activity?
- Would my colleagues, employer, the College, the funder and family/friends view my actions as acceptable?
- Would a third-party payer (e.g., an insurance company) fund the action as part of the plan of care?
- Could my actions be perceived to be inappropriate in a therapeutic or professional relationship (e.g., violate professional standards, be deemed unprofessional conduct, or break the law)?

If a boundary crossing is suspected, it is important to take action:

- Reflect on what led to the boundary crossing.
- Consult with colleagues and/or ACSLPA representatives, as required.
- Take necessary steps to re-establish the therapeutic or professional relationship, if possible. This may include clarifying the roles of the regulated member and the client, as well as therapeutic goals.
- Terminate treatment if the therapeutic or professional relationship cannot be re-established. Considerations when taking this action include:
    - Advising the client of the reasons that treatment must be discontinued.
    - Advising the client that continuing with their care would not be in their best interest.
    - Ensuring the client is not adversely affected by any interruptions in care (e.g., by providing options for alternative care providers if care is still required).
- Document the actions that lead to the boundary crossing and actions taken to re-establish or terminate the therapeutic or professional relationship.

## Clients Crossing Professional Boundaries

During the delivery of health services, situations can arise when the client crosses professional boundaries and demonstrates inappropriate behaviour or remarks toward the regulated member. In this case, it is the responsibility of the regulated member to ensure that professional boundaries are maintained. The following strategies should be considered to manage boundary crossings and promote patient safety.

- Identify situations of high potential risk for boundary crossings and sexual abuse and/or sexual misconduct and conscientiously take active measures to maintain professional boundaries.
- Think before acting or speaking, and refrain from any comments or actions that could be misinterpreted.
- If a client makes sexual advances and/or comments/gestures of a sexual nature, or otherwise attempts to cross a professional boundary, regulated members should use their judgement and implement the following actions as necessary:
    - Refuse to be engaged; explain the ethical and regulatory responsibilities of maintaining professional boundaries.
    - Remove themselves from unsafe environments if the actions of the client cause the regulated member to be concerned about their safety.
    - Discharge the client and transfer them to another provider. Regulated members must ensure that appropriate discharge procedures (including documentation) are followed if this step is taken.

- Document in the client's chart the dates, the nature of their conduct and remarks and the measures taken to maintain professional boundaries.
- Report the client's behaviour to a supervisor or colleague. Regulated members should review and comply with any employer policies on reporting and documentation of clients crossing boundaries.
- Consult with colleagues and ACSLPA representatives as required.

## Ethically Grey Interactions/ Boundary Blurring

There is often a grey zone of behaviours that may or may not be appropriate, and it can sometimes be difficult to know if a line has been crossed. For example, there may be situations where a single comment or action may seem harmless, but when considered with other behaviours could result in a situation where the professional boundary has been compromised or crossed.

In ethically grey interactions, the appropriate course of action may not be immediately or overtly apparent. Consider the example of an SLP or Audiologist sharing their own personal experience of a similar circumstance after a client discloses sensitive information. The professional's disclosure may normalize the client's feelings, reduce embarrassment, and build rapport; OR it may alter the focus of the interaction from client to practitioner, which left unchecked may shift the relationship from therapeutic or professional to personal.

Navigating ethically grey areas requires the use of good judgement and careful consideration of the context. The most appropriate decision will be contextual and will require a case-by-case analysis of the regulated member's personal values, the client's needs, professional standards and ethics, and any institutional or organizational policies.

The following examples illustrate ethically grey situations where boundaries may become blurred and there is an increased risk of boundary crossing. The examples show how seemingly insignificant or innocent actions may lead to boundary crossing. Each example poses questions/considerations for the regulated member to reflect on in order to prevent or avoid inappropriate conduct.

### Giving or Accepting Gifts

Generally speaking, giving and accepting gifts are part of a personal relationship rather than a therapeutic or professional relationship. A small gift given as a token of appreciation by a client may in some cases be acceptable. However, giving or accepting a gift may also suggest that a personal relationship is developing and may cause confusion for the client. Accepting a gift from a client can carry some degree of risk, so it is important to consider the context of the situation. The table below shows how situational factors affect the risk of accepting a gift from a client.

| Less Risk | More Risk |
|---|---|
| Token value | Valuable (money or meaningful) |
| For a group | To an individual |
| 'Thank you' at discharge | During the course of treatment |
| Spontaneous | Solicited |
| Edible/Sharable | Person specific |

610

611

Gift giving may be viewed differently depending on individual and cultural values and norms. It is important to consider clients' perspectives regarding gift giving and approaching situations accordingly. For example, some cultures may perceive refusal of gifts as offensive, which can unintentionally erode the therapeutic relationship. It is important to approach these situations with care, taking into consideration the impact of refusing the gift. Using discretion when accepting gifts or having universal rules around gift refusal may be helpful in these situations. In addition, clients should be provided clear and thorough explanations for why a gift cannot be accepted.

The following are questions that the regulated member may wish to consider when giving and/or receiving gifts:

- What motivated the client to give me this gift (e.g., a desire for a "special relationship" or preferential treatment, something I disclosed which made the client feel obligated)?
- What is the context of this gift giving (e.g., thank you, goodbye, 'just because' etc.)?
- Will accepting this gift affect my clinical decision-making ability with this client?
- Will accepting this gift create confusion or a misunderstanding where the client feels the relationship is personal (e.g., friendship or something more)?
- Why do I want to give a gift to this client (e.g., if I am not giving all of my patients a gift, why this one? Are my reasons in the best interest of the client?)?
- Will giving this gift make the client feel the need to give me something in return?
- Will the client's family or others think that the gift from the client was the result of theft, fraud or manipulation on my part?

It is up to the regulated member's discretion to accept or decline a gift. However, it may also be helpful for regulated members to develop strategies to discourage personal gift giving (e.g., policies that make it clear what regulated members will do with any gifts, such as donating monetary gifts to charity, or placing consumables in a staff room). This may help to minimize the pressure to give or accept gifts.

### Treating Relatives or Friends

Treating relatives/friends (including the spouses or children of relatives or friends) results in an overlap between personal and therapeutic or professional relationships that can make maintaining boundaries a challenge. This type of dual relationship should be avoided for a number of reasons:

- The regulated member may not be able to be objective.
- The regulated member may make assumptions and be less thorough.
- The patient may not want to answer questions honestly (due to embarrassment or reluctance to share confidential information).
- The client may not feel that they can refuse to provide consent.
- The regulated member may be placed in a situation of conflict of interest.
- The personal relationship may be affected, especially if the therapeutic or professional relationship is not successful.

In some instances, such as when practicing in a rural setting, it may be difficult to avoid treating relatives/friends as there may not be another provider available. In these instances, the regulated member must consider how they can manage professional boundaries to ensure that they remain objective and that the services are client-centred, and privacy/confidentiality is respected. Separating personal feelings, values, and beliefs from professional and ethical responsibilities and obligations can be difficult, and potential conflicts of interest must be acknowledged. In situations where the regulated member is considering providing services to a relative or friend, the following questions should be considered:

657

- Do I have the necessary competencies to treat this relative/friend?
- Do I feel right treating this relative/friend? Will they be at ease being treated by me?
- Will I be able to be objective and provide client-centred care?
- Will I be able to maintain my professional obligations?
- Will I be able to maintain privacy and confidentiality of all information? How will this be done?
- How will differing opinions be managed, if they occur? What if I disagree with the choices made by the client?
- Are financial arrangements an issue and if so, how will they be managed?
- Is any type of special treatment expected? How will this type of expectation be managed?
- Will I be able to discontinue the services if/when required?

Regulated members providing services to relative or friends should inform themselves about liability concerns, and be aware that third-party payers may require such a treatment relationship to be disclosed. In addition, the conflict of interest of treating a relative or friend and the processes put in place to manage the conflict of interest must be documented in the client file.

## Social Media

The same professional obligations for face-to-face interactions with clients also apply for online activities. As a result, the regulated member needs to reflect on how to establish and maintain professional boundaries when using social media for professional and personal purposes.

Regulated members should consider the following when using social media:

- Developing clear and comprehensive policies if using social media for business.
- Maintaining a high standard of E-Professionalism on social media.
- Managing friend requests from clients in a manner that avoids conflicts of interest.
- Avoiding giving professional advice on online platforms.
- Maintaining a professional communication style in all electronic communications.
- Establishing and maintaining separate personal and professional social media pages and email accounts. Keep your personal life private.
- Assuming that every post is public. Posts intended to be private or for friends only are easily shared.
- Respecting client privacy and confidentiality. Do not post on social media any information where a client may be identified. Do not initiate personal online contact with patients.
- Developing or referring to workplace policy for responding to client requests for online communication.

## Touch and Proximity

Many clients, due to factors such as culture, background and/or individual preferences, are uncomfortable when others come too close and invade their personal space. Regulated members, during the delivery of health services, must approach patients respectfully and thoughtfully, and with sensitivity, recognizing that one's tolerance for touch and proximity is highly individual. Physical proximity and actions such as an innocent comforting hug or a pat on the knee of encouragement could be misinterpreted by clients and lead to accusations of sexual abuse or sexual misconduct.

Although clients may be aware that physical contact/touch is a requirement of many therapeutic procedures before seeking care, regulated members cannot assume that the client fully understands, or consents to physical contact. Regulated members should also remain mindful

that physical contact/touch as part of the provision of services may be misunderstood by the client. Some examples of physical contact/touching commonly used by speech-language pathologists and audiologists, which could be misinterpreted include:

- Tactile facial prompts provided as part of phonological therapy.
- Abdominal and/or chest touch during breathing exercises.
- Close physical proximity and facial/head contact as part of an audiologic assessment or hearing aid fitting.
- Contact with the neck and face during feeding and swallowing interventions.

The regulated member should ensure that the client understands the intent and nature of the touch and proximity and consents to the physical contact throughout the delivery of professional services. The following provides some considerations for respectful physical contact with clients:

- Recognize how culture and past experiences can affect the client's attitude about physical contact.
- Recognize that physical contact is context specific (e.g., consent for treatment does not necessarily include consent for physical contact such as hugging).
- Keep in mind that consent must be specific and ongoing:
    - Always ask for consent prior to touching a client.
    - Always explain the reason and nature of physical contact as part of asking for consent.
    - Check-in regularly with the client throughout the treatment to ensure you have ongoing consent.
    - Keep in mind that the client has the right to revoke or change what they are consenting to at any time.
- Use gloves as required for infection control and to reduce intimacy.
- Use appropriate draping to respect client dignity at all times.
- Avoid unnecessary physical contact and use physical barriers (e.g., pillows or draping) to prevent contact with other body parts.

Special consideration is required for clients who cannot give consent for touch and proximity independently, for example pediatric clients (except in the case of mature minors) or adult clients in care who require surrogate decision makers. While these clients cannot give consent for care independently, it is still important to involve them in the process of obtaining consent for touch and proximity, as this may helps with establishing rapport and building trust into the professional relationship. Care should be taken to involve the client in the consent process, explaining the purpose and reasoning behind any physical touch, ensuring to obtain the consent from both the client as well as their guardian/parent whenever possible.

Occasionally, client norms around physical touch and proximity may differ from what is expected in a professional therapeutic context (e.g., preschool aged clients, clients with autism spectrum disorder, clients with different cultural norms around touch, etc.). Although professionals do not have to accept touch that they are uncomfortable with (e.g., kisses or hugs), is important to take into consideration these contextual factors when interpreting client behaviour and acting accordingly to find alternatives or discuss boundaries. For example, obtaining weighted items of clothing, such as vests, in replacement of the deep pressure experienced by a hug for clients with sensory preferences. To maintain the integrity of the professional relationship, regulated members should acknowledge and explain why touch cannot be accepted in a manner appropriate to the client's understanding.

## Culturally Sensitive Care

The client's culture may influence their health-related priorities, decisions, and behaviours. Culturally sensitive care considers the preference and expressed needs of the client which may be influenced by their culture (e.g., the involvement of family members or friends in their care, preference for the care provider to be the decision maker for their care).

While it is impractical to have an in-depth knowledge of all the cultures that one may encounter in daily practice, understanding a client's culture allows their care to be customized to better address their needs. Although regulated members must be sure to treat clients as individuals and avoid stereotyping based on membership in certain groups, there are some strategies that members can use to promote cultural sensitivity in the care that they provide. These include:

- Acknowledging and reflecting upon your own culture. Recognize that both the client and provider bring their culture to the therapeutic or professional relationship.
- Being open to learning about the client's culture or beliefs, incorporating cultural practices into client care.
- Asking the client before incorporating cultural practices you believe would be associated with their perceived culture based on appearance or presentation.
- Respecting the legitimacy of the client's health beliefs.
- Applying a biopsychosocial model approach to health care. Please see the ACSLPA guideline: Anti-Racist Service Provision for Speech-Language Pathologists and Audiologists for more information on the biopsychosocial model of healthcare.
- Encouraging the client to discuss their explanations of their concerns/diagnosis and its perceived causes.
- Discussing your understanding of the client's diagnosis/concerns and its perceived causes, using patient friendly language.
- Encouraging the client to participate in the planning, implementation, and evaluation of their own care plans.
- Negotiating an understanding and a safe, effective, and mutually agreeable treatment plan.
- Maintaining an awareness of using verbal and nonverbal communication which avoids cultural harm (i.e., demeaning or diminishing the patient's culture, culturally based explanations of their concerns, or cultural health practices). Please see the ACSLPA guideline: Anti-Racist Service Provision for Speech-Language Pathologists and Audiologists for more information on cultural harm and practicing cultural safety.

## Trauma Informed Service Delivery

While ACSLPA regulated members do not provide services to treat trauma directly and specifically, they can incorporate trauma-informed practices into their service delivery. This involves developing an understanding of the lived experiences and ongoing impacts of trauma, developing ways to effectively manage the impacts of trauma on a client, and avoiding or minimizing retraumatization.

### The Definition of Trauma

The Substance Abuse and Mental Health Services Administration (2014) defines trauma as an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening, with lasting effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Some examples of traumatic experiences are:

- Sudden, unexplained separation from a loved one
- Physical, sexual, or emotional abuse
- Childhood neglect
- Poverty and discrimination
- Family members with a mental health disorder
- Family members with a substance use disorder
- Violence in the community
- Natural or human-made disasters
- Forced displacement

Trauma is common and often undiagnosed. Members of historically marginalized groups have a disproportionately higher prevalence of trauma than the general population. This includes people from low-income communities, ethnic and racial minorities, LGBTQ individuals, people with disabilities, and women and girls.

Many individual, contextual, and environmental factors impact how a traumatic event affects an individual:

| Individual Factors | Contextual Factors | Interpersonal Factors | Community Factors | Societal Factors | Cultural & Developmental Factors |
|---|---|---|---|---|---|
| Age<br>Mental health status<br>Socioeconomic status<br>Temperament and other personality traits | Novelty, frequency, duration, complexity of traumatic event<br>Type of traumatic event, e.g., bodily intrusive, interpersonal | Interaction patterns with loved ones<br>Family history of trauma<br>Family mental health<br>Social network strength | School system quality<br>Work environment<br>Neighborhood quality<br>Accessibility of health and social services<br>Access to faith-based settings | Provincial and federal economic and social policies<br>Media societal norms<br>Judicial system | Cultural system norms<br>Cognitive and maturational development |

A traumatizing event may not affect two people the same: to the extent that one person may consider an event traumatic while another person may not. Not all children or adults who are exposed to traumatic events experience long-term health problems. Protective factors, e.g., healthy attachments and social connections, or social or emotional competence, may help shield an individual from lasting effects of trauma.

## Types of Trauma

This section reviews a non-exhaustive list of the various forms and types of trauma. Please note that lack of relevance is not implied if a given trauma is not listed or addressed in the following content. In addition, the order of listing of the types of traumas does not denote a specific trauma's importance or prevalence. Some forms of trauma discussed below may fit in multiple categories. The intent of this section is to give a broad perspective of the various categories and types of trauma.

**Natural or Human-Caused Trauma**

- Natural Trauma: natural events, which are typically unavoidable, which may impact a small number of people, or whole communities.
- Human-Caused Trauma: caused by human failure (e.g., infrastructure catastrophes, accidents), intentional acts (e.g., home invasion, stabbing or shooting), or by human design (e.g., war).

How survivors of natural and human-caused traumas respond to the experience often depends on the degree of devastation, the extent of individual and community losses, the amount of time it takes to reestablish daily routines and services, and the amount, duration, and accessibility of relief services. Traumas perceived as intentionally harmful often make the event more traumatic for people and communities.

**Individual, Group, Community, and Mass Trauma**

- Individual trauma: an event that only occurs to one person – a single event (e.g., mugging, physical injury, assault), or multiple or prolonged events (e.g., a life-threatening illness, multiple assaults).

  Although the trauma directly affects one individual, others who know the person will likely experience emotional repercussions from the event(s) as well. Survivors of individual trauma may not receive the environmental support that members of collectively traumatized groups and communities receive. They are less likely to reveal their trauma or to receive validation of their experiences. Often, shame distorts their perception of responsibility for the traumatic event(s).
- Group trauma: traumatic experiences that affect a particular group of people, whereby the experience of trauma and the characteristics of trauma-related reactions are unique to a small group of people. Groups may share identity, history, activities, or concerns e.g., first responders responding to a crisis, and military servicepeople.
- Trauma affecting communities and cultures: this can cover a broad range of violence and atrocities that erode the sense of safety within a given community (e.g., schools, neighborhoods, reserves). It may involve:
  - Assaults, hate crimes, violence;
  - Actions that attempt to dismantle systemic cultural practices, resources, and identities (e.g., the residential schooling system);
  - Indifference or limited responsiveness to specific communities or cultures that are facing potential danger; and/or
  - Events that erode the heritage of a culture (e.g., prejudice, disenfranchisement, heath inequities).

This type of trauma includes:

- Historical or generational trauma - widespread events that affect an entire culture and influence generations of the culture beyond those who experienced them directly. Historical trauma can increase the vulnerability of multiple generations to the effects of traumas that occur in their lifetimes.
- Mass trauma - events that affect large numbers of people directly or indirectly. In mass traumas, the initial event often causes additional traumas and other stressful events that lead to more difficulties.

**Interpersonal Traumas**

Events that occur (and typically tend to reoccur) between two people who often know each other, such as spouses, or caregivers and their children. Examples include physical and sexual abuse, intimate partner violence, or elder abuse.

**Developmental Traumas**

Specific events or experiences that occur within a given developmental stage and influence later development, adjustment, and physical and mental health. Often, these traumas are related to adverse childhood experiences, but can occur from any event in the life cycle that create significant loss or have life-altering consequences.

**Political Terror and War**

Anything that threatens the existence, beliefs, well-being, or livelihood of a community. Political terror and war are likely to have lasting consequences for survivors. Examples include the trauma experienced by political asylum seekers and refugees.

**Retraumatization**

Retraumatization occurs when clients experience something that makes them feel as though they are undergoing another trauma. Re-traumatization is any situation or event that resembles an individual's trauma (literally or symbolically) which then triggers difficult feelings and reactions associated with the original trauma.

Treatment settings can create retraumatizing experiences, often unintentionally, and sometimes clients themselves are not consciously aware that the clinical situation has triggered a traumatic stress reaction. Staff and agency issues that can cause retraumatizing include:

- Clients being asked to continually retell their story.
- Challenging or discounting reports of abuse or other traumatic events.
- Using isolation or physical restraints.
- Allowing the abusive behaviour of another staff member or client towards the client.
- Failing to provide adequate security and safety within the clinical environment.
- Limiting the participation of the client in treatment decisions and planning.
- Minimizing, discrediting, or ignoring client responses.
- Clients feeling like they are treated 'as a number' rather than as a person.
- Disrobing being required for healthcare procedures.
- Clients feeling like they are seen as their diagnosis or label (e.g., addict, schizophrenic).
- No choice being offered in services or treatment provided, or when services are non-collaborative.
- Clients feeling like they are not being seen or heard by their healthcare provider.

Organizations that anticipate the risk of retraumatization and that are sensitive to the histories and needs of individuals who have undergone trauma are likely to have more success in providing care, retaining clients, and achieving positive outcomes.

## The Impact of Trauma

Trauma informed care involves a broad understanding of traumatic stress reactions and common responses to trauma. The table below highlights some common short- and long- term responses to traumatic experiences. These reactions are often normal responses to trauma but can still be distressing to experience. Such responses are not signs of mental illness, nor do they indicate a mental disorder. This information is presented so that regulated members can increase their awareness of, and sensitivity to, how trauma can affect presentation, engagement, and outcomes in the clinical relationship. **However, making clinical inferences or diagnoses related to trauma, or treating trauma responses are outside the scope of practice for ACSLPA regulated members.**

| Domain | Immediate Reactions | Delayed Reactions |
|---|---|---|
| Emotional | Numbness and detachment<br>• Anxiety or severe fear<br>• Guilt<br>• Exhilaration<br>• Anger<br>• Sadness<br>• Helplessness<br>• Disorientation<br>• Depersonalization (i.e., feeling as if you are watching yourself)<br>• Feeling out of control<br>• Denial<br>• Feeling overwhelmed | Irritability<br>• Hostility<br>• Depression<br>• Mood swings or instability<br>• Anxiety<br>• Fear of trauma reoccurrence<br>• Grief<br>• Shame<br>• Feelings of fragility/vulnerability<br>• Emotional detachment (e.g., relationships, conversations) |
| Physical | • Nausea or gastrointestinal distress<br>• Sweating or shivering<br>• Faintness<br>• Muscle tremors or uncontrollable shaking<br>• Increased heartrate, respiration, and blood pressure<br>• Extreme fatigue or exhaustion<br>• Greater startle response<br>• Depersonalization | • Sleep disturbances<br>• Appetite and digestive changes<br>• Lowered resistance to colds and infections<br>• Persistent fatigue<br>• Hyperarousal<br>• Long-term health effects (e.g., liver, heart, and autoimmune disease) |
| Cognitive | • Difficulty concentrating<br>• Rumination or racing thoughts<br>• Distortion of time and space (e.g., events seeming like they are happening in slow motion)<br>• Memory problems | • Intrusive memories of flashbacks<br>• Self-blame<br>• Preoccupation with the traumatic event<br>• Difficulties making decisions<br>• Magical thinking<br>• Generalization of triggers |

| | | |
|---|---|---|
| Behavioural | • Startled reaction<br>• Restlessness<br>• Sleep and appetite disturbance<br>• Difficulty expressing oneself<br>• Argumentative behaviour<br>• Increased use of alcohol, drugs, or tobacco<br>• Withdrawal and apathy<br>• Avoidant behaviours | • Avoidance of event reminders<br>• Social relationship disturbances<br>• Decreased activity levels<br>• Engagement in high-risk behaviours<br>• Increased use of alcohol or drugs<br>• Withdrawal |
| Existential | • Intense use of prayer<br>• Loss of self-efficacy<br>• Despair about humanity<br>• Immediate disruption of life assumptions (e.g., sense of fairness, safety, goodness of self and others) | • Questioning (e.g., "why me?")<br>• Increased cynicism or disillusionment<br>• Increased self-confidence<br>• Loss of purpose<br>• Renewed faith<br>• Hopelessness<br>• Reestablishing priorities<br>• Redefining meaning and importance of life |

Experiencing traumatic events increases an individual's risk of long-term physical and behavioral health issues and affects health throughout the lifespan. The more an individual is exposed to a variety of stressful and potentially traumatic experiences (especially as a child), the greater the risk for chronic health conditions and health-risk behaviors.

Trauma is thought to overwhelm a person's coping capacity, resulting in adaptive yet unhealthy coping mechanisms. Over time, these coping mechanisms can evolve into health risk behaviors and conditions e.g.,

- Unhealthy eating habits
- Autoimmune disease
- Social isolation
- Chronic disease e.g., lung, liver, or heart disease
- Substance use disorders
- Depression
- Anxiety

The effects of trauma may show themselves in therapeutic relationships with clients, e.g.:

- Impaired memory, concentration, new learning, and focus.
- Impaired ability to trust, cope, and form healthy relationships.
- Disrupted emotional regulation and the ability to distinguish between what is safe and unsafe.
- Impacted beliefs about self and others, and outlook on life.
- Experiencing defensive responses (fight, flight, or freeze), even in situations that are not life-threatening.
- Rejection of care.
- Other emotional, behavioural, physical, or cognitive trauma reactions, e.g., flashbacks, dissociation, self-harm.

ACSLPA regulated members are not expected to directly treat any of the above trauma related reactions as part of service provision. However, regulated members should be sensitive and responsive to any trauma related reactions and seek appropriate referrals and/or resources for clients as needed.

## Trauma Informed Care

Trauma informed care understands and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize. Trauma informed care acknowledges that understanding a client's life experiences is key to improving engagement and outcomes. Providers who understand the connection behind trauma and health are able to create clinical environments that are less triggering, identify appropriate referrals, and develop more effective therapeutic alliances with clients.

Trauma informed approaches are a crucial aspect of high-quality healthcare. They can improve client engagement, treatment adherence, and health outcomes, as well as mitigate risks to physical and mental health. Trauma informed care shifts the focus of care from 'what's wrong with you?' to 'what happened to you?' by:

- Developing and maintaining awareness of:
  - The commonness of trauma experiences,
  - The impact of trauma on development,
  - The wide range of adaptations used to cope with trauma, and
  - The relationship between trauma, substance use, and physical and mental health.
- Realizing the widespread impact of trauma and understanding potential paths to recovery.
- Being sensitive and responsive to signs and symptoms of trauma in clients and families.
- Integrating knowledge about trauma into policies, procedures, and practices.
- Seeking to actively resist re-traumatization (i.e., avoid creating an environment that reminds clients of traumatic experiences and causing them to experience emotional and biological distress).

Trauma informed care is grounded in principles of dignity, respect, and justice. It takes the client's experience of trauma into account when providing services and is attuned to a range of experiences, relevant to the people and communities served. While SLPs and Audiologists should not directly target healing from trauma in their clinical goals, engaging in trauma-informed practice within the therapeutic relationship may support a more effective therapeutic relationship.

### Core Principles of Trauma Informed Care

There are five guiding principles that serve as a framework for trauma informed care. The figure below outlines these principles, with examples of trauma informed care practices that can be put into place.

**Safety**

Oftentimes, people who have experienced trauma have experienced abuses of power in relationships, in the past and/or present. Safety involves implementing strategies to help clients feel physically and psychologically safe. Some examples of safety in practice include:

- Providing safe physical environments (e.g., well-lit areas, clear access to doors, reduced noise levels).
- Providing safe, calm, predictable, and transparent socio-emotional environments (e.g., welcoming/greeting clients warmly, having consistency in scheduling and procedures).
- Responding to trauma disclosures in an empathetic and supportive manner that validates the client's experience and reaffirms their autonomy.
- Clearly explaining to the client what they can expect in the session, or asking the client or their caregiver what might make them most comfortable.

- Creating space for emotions and giving clients the opportunity to regulate or manage their emotions. For example, by providing time, materials to write and/or draw, and/or physical space for a support person.

**Choice**

Giving the client the experience of choice helps to foster a sense of self-efficacy, self-determination, dignity, and personal control. Choice in the provision of trauma informed professional services may look like:

- Informing clients about their treatment options, so that they can choose the option they prefer.
- Giving choice and control to the client wherever possible.
- Using a robust process for obtaining informed consent for services.

**Collaboration**

Collaboration can provide the opportunity for (re)building safe relational connections for those who have experienced or are experiencing trauma. Collaboration involves:

- Making decisions with the client.
- Sharing power with the client to support shared decision making.
- Maximizing collaboration among healthcare staff, clients, and families.
- Engaging referral sources and partner organizations as needed.
- Giving clients the opportunity to plan and evaluate the services that were provided to them.

**Trustworthiness**

People who have experienced trauma often scrutinize authority figures (e.g., healthcare providers) for evidence that they are trustworthy, in order to protect themselves from further harm. It is important to recognize that this scrutiny is not personal or about the practitioner's skills but is instead influenced by the past or an anticipation of what is to come. Trustworthiness in practice involves:

- Transparency in decision making, with the goal of building and maintaining trust.
- Creating clear expectations with clients about what proposed treatments entail, who will provide services, and how care will be provided.
- Creating spaces that allow for privacy, confidentiality, and community.
- Maintaining respectful and professional boundaries.

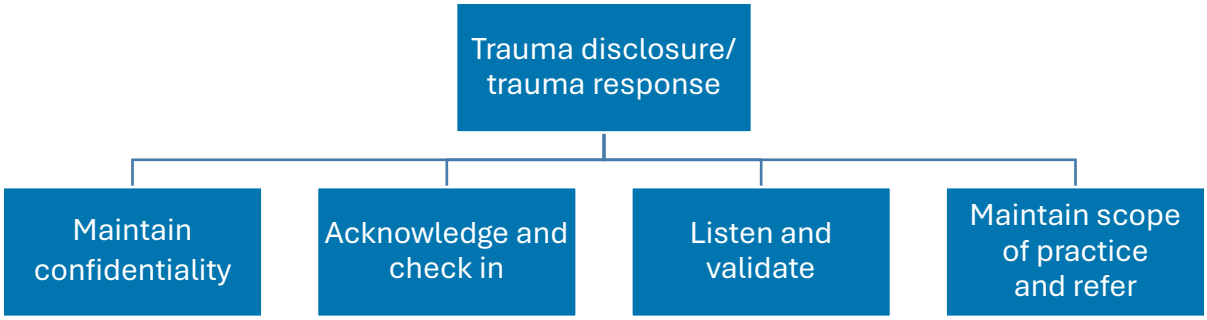
**Empowerment**

Empowering clients involves recognizing, building on, and validating client strengths. Empowerment honors what safety means for the client and can further develop resiliency and coping skills. Empowerment in practice may look like:

- Allowing clients to co-create treatment plans with their providers.
- Giving clients opportunities to identify what they are and are not comfortable with and honoring their choices.
- Not starting treatment until the client approves the approach that will be taken.

## Responding to Disclosures or Trauma Responses

In the case of client disclosure of trauma or client demonstrating a trauma response, practitioners should be mindful of the following practices:




**Maintain Confidentiality**

Regulated members should review confidentiality requirements, which may differ for adult and pediatric clients. In situations where documentation of the disclosure is legally or ethically required, the practitioner could ask "I'm wondering how you would like me to note what you have told me on your health record?" Clients must also be informed of any reporting requirements for the practitioner.

In situations where documentation is not required, the practitioner could ask what the client would like recorded in their health record, e.g., "This is an important conversation, I'm wondering what, if anything, you'd like me to write in your file?"

**Acknowledge and Check in**

SLPs and Audiologist should not directly ask clients if they have a history of trauma. However, regulated members should be mindful of and pay attention to verbal and non-verbal cues that something feels 'off' for the client. If anything unusual is detected, members can acknowledge their observation and check in with the client. For example, "You seem a bit uncomfortable, so I want to check in with you. Is there anything about the appointment or something that I'm saying or doing that is making you uncomfortable? How can we make that better?"

Members may be able to provide the client with some options to regulate or exercise choice in the moment. For example, a regulated member can ask if the client is ok to continue with the session; if they would like a few minutes to regroup or if they would like to reschedule for a different day.

**Listen and Validate**

In the event of a trauma disclosure, regulated members should listen to the client's story, without asking for details. The information that is shared should be acknowledged with empathy. Practitioners should validate what is shared; it is important that clients see and hear from their provider that their experience is believed and that there is appreciation for the courage it took to share their story.

**Maintain Scope of Practice and Refer**

Treating trauma is outside of the scope of practice for ACSLPA regulated members. As such, giving advice or counselling the client is a professional overstep. However, regulated members can initiate referrals as needed to appropriate healthcare professionals (with the client's consent) who can provide clinical treatment for trauma and its impacts. Regulated members must also respond to immediate safety concerns (i.e., threats of violence in the home, self-harm, child safety, etc.) with appropriate referrals.

# APPENDIX A: Examples of Potential Sexual Abuse and Sexual Misconduct Situations

**This appendix provides examples of potential situations that could lead to sexual abuse and/or sexual misconduct. Considerations for regulated members are outlined in order to prevent allegations of sexual abuse and/or sexual misconduct.**

## 1. A Patient Makes Unwanted Sexual Advances

A speech-language pathologist is running a fluency group for adult stutterers. A male patient in the group is always trying to get her attention, complimenting her looks and consistently staying after the group making sexual advances. He repeatedly asks the speech-language pathologist to go out on a date.

The regulated member should consider the following steps that can be taken when a patient crosses professional boundaries:

- Outlining to the patient the nature of the therapeutic relationship and how professional boundaries must be maintained at all times throughout the delivery of health services.
- Refusing to be engaged; explaining the ethical and regulatory responsibilities of the therapeutic relationship and maintaining professional boundaries.
- Documenting in the patient's chart the dates, the nature of their conduct and remarks, and the communication with the patient about their behaviour.
- Discharging the patient and transferring them to another provider if required for patient and clinician safety, following appropriate discharge procedures (e.g., documentation).
- Reporting the patient's behaviour to a supervisor or colleague and following any other workplace policy on responding to situations of this nature.

## 2. Physical Proximity and Touch During a Clinical Interaction

A male audiologist is working alone in an office at night. A young female patient is being seen for a vestibular assessment in a darkened room; there usually are no other individuals in the waiting or treatment rooms. Portions of the vestibular assessment require physical touching of the patient's head and neck area.

The regulated member should consider the following to promote patient safety and a safe environment for the patient:

- When booking the appointment, openly explain to the patient the nature of the assessment setting and invite them to rebook or bring someone along if there are concerns, particularly around the time of day that the appointment will take place.
- Prior to starting the assessment, explain the various steps that are involved, the positioning of the patient, where and how they will be touched.
- Obtain the patient's informed consent and remind them that they can stop the procedure at any time if they are uncomfortable.
- Reassure and check regularly with the patient throughout the procedure to ensure that they understand and continue to consent.
- In the patient's chart, document consent, refusal (if appropriate), concerns and reactions.

### 3. Romantic Relationship with a Patient

The audiologist and the patient were attracted to each other and had a friendly professional relationship. During the delivery of health services, they met accidentally, at a cross-country ski club that they had both independently joined. After a month of meeting weekly for cross country skiing and social interaction, they contemplated starting a romantic relationship.

The regulated member should consider the following to prevent and avoid any allegations of sexual abuse:

- Abstain from entering into a romantic or sexual relationship with a patient regardless of the patient's consent and behavior.
- At the earliest signs of any romantic feelings:
  - Explain to the patient that professional behavior must be guided by regulatory and ethical responsibilities,
  - Discuss the nature of the therapeutic relationship and how professional boundaries must be maintained at all times throughout the delivery of health services, and
  - Discharge the patient and transfer to another provider.
- Consult with colleagues and ACSLPA representatives as required.
- Document the management of the situation.

### 4. Sexual Relationship with a Former Patient

A female speech-language pathologist treated a male patient with moderate post brain injury, one on one, for a year. A year passed and they happened to meet in the community, began dating and contemplated starting a sexual relationship.

The regulated member should consider the following to prevent and avoid any allegations of sexual abuse:

- Determine whether the time interval that has passed since the last health services were provided is sufficient to ensure that there is no lasting power imbalance and dependency from the therapeutic relationship.
- Determine if the former patient has the capacity to understand that the therapeutic relationship is over, and the power imbalance no longer exists.
- Reflect on the nature of the patient's injury, their degree of vulnerability and the extent to which issues of a personal nature were discussed during the delivery of health services.
- Consult with colleagues and ACSLPA representatives as required.
- When the above are taken into account, the regulated member may decide that it would never be appropriate to enter into a sexual relationship with this former patient.
- If the regulated member does decide to enter into a sexual relationship with the former patient, should speech-language pathology/audiology services be required in the future, the individual should be transferred to another appropriate provider.

# References


Alberta College of Speech-Language Pathologists and Audiologists. (2022). *Code of ethics*. https://www.acslpa.ca/code-of-ethics/

Alberta College of Speech-Language Pathologists and Audiologists. (2023). *Standard area 5.0 sexual abuse and sexual misconduct*. https://www.acslpa.ca/members-applicants/standards-of-practice/

College of Audiologists and Speech-Language Pathologists of Ontario. (2023). *Professional relationships and boundaries position statement*. http://www.caslpo.com/sites/default/uploads/files/PS_EN_Professional_Relationships_and_Boundaries.pdf

College of Physiotherapists of Alberta. (2024). *Therapeutic relationships guide for Alberta physiotherapists*. https://www.cpta.ab.ca/docs/87/Therapeutic_Relationships_Guide_2024.pdf

College of Registered Nurses of Alberta. (2023). *Professional boundaries: Guidelines for the nurse-client relationship*. https://nurses.ab.ca/media/wh2dakm2/professional-boundaries-guidelines-for-the-nurse-client-relationship-2022.pdf

College of Registered Nurses of Alberta. (2019). *Protection of patients from sexual abuse and sexual misconduct standards*. https://nurses.ab.ca/media/prrjzrog/protection-of-patients-from-sexual-abuse-and-sexual-misconduct-standards-2022.pdf

College of Speech and Hearing Health Professionals of British Columbia. (2019). *Clinical practice guideline: Where's the line? Professional boundaries in the therapeutic relationship*. https://cshbc.ca/wp-content/uploads/2019/02/CSHBC-CPG-05-Professional-Boundaries-Where-is-the-Line.pdf

Substance Abuse and Mental Health Services Administration. (2014). *Trauma-informed care in behavioural health services: A treatment improvement protocol*. https://www.ncbi.nlm.nih.gov/books/NBK207201/