

Sexual Abuse Prevention Guidebook

College
of
Occupational
Therapists
of Ontario





The Issue

The power imbalance. When a patient is being treated, the patient makes the assumption that the occupational therapist knows much more than he or she does. This places the occupational therapist in a position of power with the patient.

The issue is the power imbalance and boundaries. If an occupational therapist uses this position of power to cross boundaries, this is an abuse of power. When boundaries relating to personal dignity, privacy, control and professional detachment are breached it can lead to or be perceived as sexual abuse.

The focus is on boundaries. Why they are necessary for occupational therapists, setting them, how they help both the professional and the patient, and warning signs that the power imbalance is not being respected and that appropriate boundaries are being trespassed.

Boundaries define your personal space. Your personal space is the physical and emotional area which you feel should be under your control. When someone invades your personal space, you are likely to feel ill at ease and defensive.

Boundaries are different for everyone. Have you ever been at a party where someone you were talking to stood too close to you and when you moved away the person kept moving into your personal space? Have you ever been asked a question which you felt was far too personal? These are examples of the differences in personal boundaries.

Why set boundaries?

Occupational therapists are in a unique relationship of trust with their patients. The professional relationship is an unequal relationship. This is due to the occupational therapist's position and the patient's own ill-health and lack of knowledge. The patient needs to establish trust in the professional much more quickly and completely than he/she might do otherwise. Therefore, setting and observing boundaries is critically important for occupational therapists. Violating these boundaries is an abuse of power.

Who is the patient? In keeping with the *Regulated Health Professions Act*, whether a person is considered a patient depends on the nature of the relationship between the person and the registrant in the particular circumstances. Patient could include a child's parent.

As an occupational therapist, setting boundaries is necessary for your patient and essential for you. You set boundaries to ensure that the trust your patient has placed in you is not betrayed. In setting boundaries, you work to ensure that treatment goals will be reached and your words and actions will not be misinterpreted by the patient.

Whose responsibility is it? It is the responsibility of the occupational therapist, the person with the most power in the registrant/patient relationship, to establish and maintain the trust relationship and to avoid crossing the boundaries. When boundaries are violated and there is an abuse of power, the occupational therapist will ultimately be held responsible. The onus is on the occupational therapist to recognize issues of power and control, be alert to and respect boundaries, and practise in a manner which establishes and preserves the patient's trust.

How is trust established?

Competence. The patient believes that you have the professional skill, knowledge and judgment to provide quality service.

Integrity. The patient believes that you will regard him/her as an active and valued participant within the relationship and that you will neither violate nor control him/her. The patient believes that you will identify the competing interests of different patients and objectively address their needs; that, within this context, you will work in the best interests of the patient. The patient believes that you will seek the advice and counsel of others when required and that you will refer him or her to the appropriate professional when the situation is outside your expertise. The Standards of Practice, the *Occupational Therapy Act* (1991) and the Code of Ethics set specific standards and limitations to ensure the integrity of professional practice.

Dependability. The patient believes that you will follow through on your commitments.

Boundaries and Preventing Sexual Abuse

The issue of boundaries is a broad one, covering such issues as financial dealings, conflict of interest, and breach of confidentiality. When boundaries relating to personal dignity, privacy, control and professional detachment are breached it can lead to or be perceived as sexual abuse. This Guidebook deals with preventing those boundary violations.

The Legal Environment

Instances of boundary violations by health practitioners leading to sexual abuse led the Ontario government to include a section on the prevention of sexual abuse in the *Regulated Health Professions Act* (RHPA) (1993).

The RHPA requires each professional College to:

- Institute mandatory reporting of sexual abuse,
- Provide funding for therapy and counselling of patients who have been sexually abused by a registrant, and
- Develop a Sexual Abuse Prevention Program for members that will significantly reduce the potential for sexual abuse by members of the profession.

Each College is required to establish a Sexual Abuse Prevention Program to include:

- Educational requirements for registrants,
- Guidelines for the conduct of registrants with patients,
- Training of College staff, and
- The provision of information to the public.

Sexual Abuse of a patient by a registrant is defined in the RHPA as:

- Sexual intercourse or other forms of physical sexual relations between the registrant and the patient;
- Touching, of a sexual nature, of the patient by the registrant; or
- Behaviour or remarks of a sexual nature by the registrant towards the patient.

‘Sexual nature’ does not include touching, behaviour or remarks of a clinical nature appropriate to the services provided.

The College’s Philosophy on Sexual Abuse

Zero Tolerance. The College of Occupational Therapists of Ontario has adopted the position of zero tolerance toward all forms of sexual abuse within the registrant / patient relationship. The registrant / patient relationship is based on mutual trust, respect, defined role boundaries, and clear communication. Any act of sexual abuse is a misuse of power and a betrayal of the registrant / patient relationship. Accordingly, all registrants of the College must recognize that they are accountable for their behaviour with patients at all times. Any form of sexual abuse of the patient under any circumstances is unacceptable and will not be tolerated.

The College is committed to the prevention of sexual abuse through the education of its registrants and the public. The College recognizes the importance of ongoing education that will enable registrants to foster and develop positive relationships with the recipients of direct care. It is the expectation of the College that registrants review their practices and individual behaviours in light of the *Regulated Health Professions Act* and College documents on sexual abuse.

All sexual abuse complaints or reports made against a registrant will be formally investigated by the College. When warranted, appropriate disciplinary action will be taken against the registrant. The College acknowledges the potential vulnerability of the patients who lodge sexual abuse complaints against registrants and will provide an accessible reporting process that is sensitive to their needs.

The COTO Sexual Abuse Complaint and Report Process

Sources of Complaints / Reports

On receipt of a complaint of sexual abuse from a patient or of a mandatory report of sexual abuse from a regulated health professional or operator of a facility* an investigation process is initiated.

The Complaint and Report Process – Step by Step

A complaint is reviewed by a panel of the Complaints Committee. During its review, the panel may request that the Registrar appoint an investigator.

If the matter arises from a mandatory report, the Registrar requests that the Executive Committee appoint an investigator.

An investigation includes gathering and examining relevant records, as well as interviewing the complainant, the registrant and anyone else who may have relevant information. Confidentiality is respected as fully as possible.

The right to fairness and just process for all parties is respected during any investigation. Registrants, however, may choose to obtain legal assistance in preparing written responses and submissions and may also wish to be accompanied by legal counsel at interviews.

Information obtained through an investigation is made available to both the patient and registrant. Opportunity may be offered to the registrant and the patient to provide additional comments.

If the allegation is unsubstantiated, the complaint or report is dismissed.

If the investigation produces clear and convincing evidence of sexual abuse of patient by the registrant, the Complaints Committee or Executive Committee can refer the matter to either the Discipline Committee, Quality Assurance Committee or Fitness to the Practise Committee.

Where the evidence related to a sexual abuse allegation involving remarks or behaviours of a sexual nature by the member towards the patient is convincing, the allegation can be referred to any of the above Committees.

All substantiated allegations involving physical sexual relations between the member and the patient, or touching of a sexual nature of the patient by the member (frank sexual acts), will result in an allegation of professional misconduct against the registrant being referred to the Discipline Committee.

* Under the Health Professionals Procedural Code, a mandatory report must be made by a regulated health professional who acquires, in the course of practising his or her profession, reasonable grounds to believe that another regulated health professional sexually abused a patient. A mandatory report must also be made by the operator of a health facility. The report must be made in writing to the alleged abuser's College.

The Sexual Abuse Fund

If as a result of the Discipline Hearing, a finding is made that the registrant sexually abused the patient while a patient, the person will be eligible to access funding for counselling and therapy from the Sexual Abuse Fund.

A patient may be eligible for funding for therapy and counselling under the Regulation for Alternative Requirements for access the Sexual Abuse Fund, even when no finding has been made by a panel of the Discipline Committee. Where a person is applying for funding under the alternative regulation, eligibility decisions are made by the Complaints Committee or Executive Committee after the investigation is completed. In such cases, special precautions are taken to ensure that the investigation process is fair to both the patient and the registrant.

Implications for the Registrant

A complaint of sexual abuse against a registrant – whether involving physical sexual relations between the registrant and the patient, touching of a sexual nature, or perceived behaviour or remarks of a sexual nature by the registrant towards the patient – could potentially involve the registrant in a lengthy, expensive, emotional process which could impact on the registrant's reputation.

A discipline hearing is the most serious proceeding that a regulated health professional can face and carries with it the risk of loss of registration. Section 51(5) of the RHPA sets out the penalties for a registrant who has been found guilty of committing an act of professional misconduct by sexually abusing a patient. A Panel of the College's Discipline Committee must:

1. Reprimand the member. A record of the reprimand being placed on the register and being made available to the public; and
2. Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following: (i) sexual intercourse; (ii) genital to genital, genital to anal, oral to genital, or oral to anal contact; (iii) masturbation of the member by, or in the presence of, the patient; (iv) masturbation of the patient by the member; and (v) encouragement of the patient by the member to masturbate in the presence of the member.

Further, an application for re-instatement by a person whose certificate of registration has been revoked for sexual abuse of a patient shall not be made earlier than 5 years from the revocation (Section 72(3)).

Depending on the seriousness of the substantiated allegation, a Panel of the Discipline Committee can choose, in addition to the above penalties, to (Section 51(5)):

1. Revoke the member's certificate of registration;
2. Suspend the member's certificate of registration;
3. Impose specified terms, conditions and limitation on the member's certificate of registration;
4. Reprimand the member;
5. Require the member to pay a fine of not more than \$35,000 to the Minister of Finance of Ontario; and
6. Require the member to pay all or part of the College's legal costs and expenses, the College's costs and expenses incurred in investigating the matter and the College's costs and expenses in conducting the hearing.

The Guidelines

We talked with experienced occupational therapists who practise in a variety of settings and asked how they recognize issues of power imbalance and, set and maintain professional boundaries while facilitating the therapeutic relationship with the patient. Their suggestions are contained in this Guidebook.

Each section contains:

- **The Guideline(s)**, or the principle(s) to follow to set boundaries effectively,
- **Some Basic Tips and Hints** from occupational therapists for setting and maintaining the boundaries,
- **Warning Signs**, indicators that you may be overstepping peoples' boundaries and at risk of having your words or actions interpreted wrongly, and
- **What would you do?** Actual case examples of situations which have been encountered by occupational therapists are given so you can see how the guidelines and tips and hints apply. The case studies could be used for discussions with your colleagues.

Possible responses to each of the case studies appear at the back of the Guidebook.

A cautionary note: These suggestions represent the best advice from experienced professionals on setting and maintaining boundaries. Within the real world of budget restraints and time pressures, you may not always be able to implement the suggested action. For example, it may be impossible to have two professionals attend a meeting. The guidance of your professional judgment, supplemented by the suggestions contained in this Guidebook, will help you to minimize the risk of your actions and/or words crossing boundaries and being perceived as sexually abusive.

Guideline 1: Practice Situations

In ongoing practice, the occupational therapist handles a variety of situations such as hands-on treatment, personal care assessments and training, and counselling on sexual functionality, which could be misunderstood if not handled appropriately. This section reviews a number of these situations and provides practical advice on ways to ensure that professional boundaries are maintained and that your words and actions are not interpreted as abusive.

THE GUIDELINE

Establishing and maintaining boundaries in challenging practice situations ensures that your patient is very clear about the purpose for the treatment and your intent.

Some Basic Tips and Hints

Hands-on treatment. In certain fields, such as pediatrics and physical medicine, occupational therapists are in close contact with their patients as they demonstrate positions and teach their patients to self-manage. OTs often add a symbolic boundary in these situations to ensure that the professional boundary is maintained.

Suggestions:

- In general, don't touch a patient unless there is a therapeutic reason for it.
- Before you touch a patient, explain to the patient where you will be placing your hands, the reason, and what you will do.
- Use mirror techniques when teaching parents how to work with their children. Rather than reach around a parent to guide his / her hands on the child, the OT places him/herself on the opposite side of the child and guides the parent's hands from that position.
- Use a symbolic barrier especially when full frontal contact is necessary. Try using a pillow or towel between you and your patient when you must support a patient from behind.
- Ensure that the patient is fully clothed when you demonstrate bathing or toileting techniques.

Personal Care Assessments and Training

Personal care assessments and training are a sensitive area. If boundaries are crossed, this violation could be interpreted as sexual abuse. The following suggestions present methods for maintaining your patient's dignity and the professional boundary between you.

- Ensure appropriate draping and robing at all times. Most therapists carry out demonstrations with their patients fully clothed.

- If the patient is reluctant to have you observe, ask the patient to describe how she/he completes the task or to demonstrate by adding another garment over their clothing rather than asking the patient to undress.
- In a hospital setting and if it is necessary for you to do actual dressing training, arrange to have another person present in the room and for the patient to be wearing the basic undergarments, at least. Some therapists suggest instructing the patient rather than actually providing hands-on assistance, and ensuring that the patient has as much privacy as possible in the circumstances. When escorting a patient to the washroom, OTs often advise and assist as needed, then withdraw until they are needed again.

Counselling on Sexual Functionality

A part of your practice may be to counsel patients on sexual functionality.

- One hospital has two sets of written materials: the first is fairly descriptive and has diagrams, and the second is quite clinical with no diagrams. When asked for counselling on sexual functionality, the therapist provides one or both of the booklets (according to the needs of the patient) and offers to review them with the patient at a later time if he/she has any questions.
- In a team setting, therapists may refer questions on sexual functionality to a team member of the same gender or to the patient's doctor.
- One way the OT can handle questions about sexual functioning is to use language that is anatomically correct and understandable (avoiding slang terms for body parts) and maintain a professional and businesslike manner.

If you are in a situation where you are expected to communicate in street language and where patients may be looking for you to respond to some significant issues, you may not be able to be brisk, businesslike and use anatomical language. This is the situation where your sensitivity to boundary issues is even more important, and your professionalism is essential.

Warning Signs

- Does your patient repeatedly ask you about sexual functionality?
- Does your patient ask you for dressing instruction or to accompany him/her into the bathroom, long after you are confident that the patient is independent?

Case Studies: What Would You Do?

On Joanne's third visit to a male patient, he asked her to demonstrate for him how he should masturbate. What should she do?

When Mary was demonstrating personal dressing techniques to a male patient, he seized her and gave her a passionate kiss. What should she do now? What should she do to prevent this in the future?

Guideline 2: Risk Management

Despite the occupational therapist's best practises and intent, certain situations arise which present a particular risk of being misunderstood or interpreted as sexual abuse. It is important to effectively handle situations such as hugs and signs of affection shown by patients, questionable jokes, the presentation of gifts by patients and requests for dates to avert any potential misinterpretation.

THE GUIDELINE

On occasion, you will encounter a situation which could be misunderstood. First, ensure that the professional boundaries are reinforced with the patient, then document such situations in your patient's file, as appropriate.

Some Basic Tips and Hints

Hugs and Affection. Appreciative patients, particularly patients whose personal barriers have been lowered by their medical condition, may seek to hug or kiss occupational therapists with whom they have established a rapport. Unfortunately, returning the hug or kiss may be seen as a demonstration of your personal affection for the person. In general, it is suggested that hugs and kisses be avoided to ensure that there are no misunderstandings.

However, for those situations when a patient shows affection, OTs had a wide range of suggestions:

- Gently avoid the hug or kiss. The OT may anticipate such situations and move slightly backwards to increase the personal space between herself and the patient. This non-verbal communication indicates tactfully that the action is not appropriate.
- Particularly at the end of an assignment, tactfully accept the hug or kiss but make it as brief and impersonal as possible.
- When a patient repeatedly tries to hug or kiss people, explain that the behaviour is not acceptable. In addition, ensure that the patient knows what actions (such as handshaking) are acceptable.
- In school settings, most children are now taught not to indiscriminately show affection. The OT can reinforce the training the child is receiving at school.
- Many therapists indicate that they are married or involved in a long-term relationship to divert any possible interest in them by a patient.

Handling Questionable Jokes. As a result of unease, patients may indulge in jokes or bantering which are in poor taste. Therapists face the difficult challenge of diverting the patient to more appropriate topics while not harming the rapport they must establish with the patient.

- In general, the OTs suggested that diverting the patient to other topics of discussion was the preferred tactic on the first occasion. If the jokes continued, it might become necessary for the therapist to speak to the patient directly about the issue, indicating that the language was inappropriate.
- One therapist, the leader of group sessions with patients, was approached by women in the group to ask her to tell the men to stop making jokes which were in poor taste. She brought the issue out in the meeting and the group members set their own standard of behaviour – a more effective way of handling the situation than if she had tried to speak to the men directly.

Gifts. Most occupational therapists have been presented with tokens of a patient's appreciation. They quickly assess whether the motivation behind the gift recognizes the therapeutic relationship or whether it is personal, and then take action to place the gift in the correct context.

- Some organizations have policies concerning gifts. Others do not. In general, OTs accepted token gifts (such as chocolates or a jar of homemade jam) and refused more expensive gifts.
- One therapist, presented with flowers, said she would take them back to her office for everyone to enjoy.
- One long-term patient asked to take the whole treatment team out to dinner. The team discussed this at a team meeting and accepted, as long as they could help with payment.
- When one patient presented a very personal gift to a therapist, the OT explained that she appreciated the gesture but that she could not accept it. She went on to reinforce the therapeutic nature of their relationship.

Requests for dates. The health care team often becomes like family and friends to a long-term patient, and a patient may ask a therapist for a date. All of the OTs agreed that dating a patient is absolutely not acceptable. The request for a date needs to be dealt with quickly to ensure that the patient understands the nature of the professional relationship. If there is any doubt about your ability to reassume a professional relationship with the patient, perhaps the patient should be transferred to another therapist.

In addition, OTs believe that therapists should remember the special nature of the therapeutic relationship when they consider dating a patient in the period immediately after discharge. Most recommended a 'cooling off' period proportionate to the time you were treating your patient and reflecting the nature of the therapy.

Written Records. If a patient makes an inappropriate request or remark, the OTs recommend charting the incident, using the patient's exact words without interpretation by the therapist. In some situations, the OT has called his/her office or spoken to the supervisor to alert them that a difficult situation has arisen. On the next visit, it may be preferable to send two therapists.

Confused or delusional patients may imagine events which have not happened. In one situation, a therapist charted a story which indicated signs of delusion related to her by a patient. Eventually, the patient made an allegation of sexual abuse against another member of the health care team which was not upheld, in part because the signs of delusion had been noted early.

Warning Signs

- Have you received a gift of a personal nature from a patient? What did you do?
- Are you frequently surprised by patients offering hugs and kisses? Particularly if you are an outgoing, affectionate person, your patients may be misinterpreting your intent.
- Are you purposely scheduling your meetings with your patient at odd hours, such as late in the day?
- Are you experiencing personal feelings about a patient?
- Have you been in a situation where a patient has told someone else that you behaved inappropriately and you had no notes of the situation?
- Have you left a patient meeting and commented to others about an unusual event? Did you chart the event?
- Has a patient offered you a lavish gift which you refused? Did you chart this?

Case Studies: What Would You Do?

A confused elderly male patient, being treated at his home, became convinced that John, the male therapist, was 'coming on' to him. The patient repeatedly told his family that he was concerned for his safety with the therapist. A family member came to John to relate the story and ask what to do. What should John do?

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Susan has been providing service to a young child injured in a car accident in which the mother died. The father has been very grateful for her help and has sought her advice on quite a number of parenting and other issues. At this visit, he asked Susan to go to dinner with him. She would really like to accept. How should Susan handle this situation?

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Jane had been the case manager for a male patient for quite a lengthy period of time. On her birthday, when Jane arrived at her male patient's apartment for a meeting, she was presented with a dozen red roses 'for her birthday'. What should she do?

Guideline 3: Diversity

THE GUIDELINE

Boundaries are not the same for everyone. Situations that an occupational therapist takes for granted may appear strange and intrusive to the patient, particularly if he or she is from a different country or culture or of a different race or sexual orientation. Be sensitive to the patient's culture, age, temperament, spirituality, values and life experiences and communicate clearly to help ensure that no misunderstandings arise.

Some Basic Tips and Hints

- Different generations often have different values and concerns.
- Some people are overly compliant. Some cultures or generations defer readily to authority figures. They may arrive for an assessment without any understanding of why their doctor has sent them or what is to be done. One group of OTs who see this frequently ensure that the patients 'play back' what is to be done and the reasons for it.
- Some people do not ask questions and are not forthcoming with information about their problem. This may be a cultural or a personal difference. The OTs suggested being very clear about the reasons for your questions and that you ask very specific questions to isolate the reason for the problem and to help the patient.
- Be aware that you have specialized knowledge. Relate the assessment or treatment directly to the patient's problem. You may need to do some basic instruction to ensure that the patient understands.

For example, it is unwise to assume that all people have a solid knowledge of anatomy. You might say "I would like to see how your hip moves. If your hip is not working properly, this may be the reason your left leg is shorter than your right leg." This approach prevents any misunderstanding of why you wish to view the patient's hip.

- Be sensitive to cultural differences. Some cultures require another family member to be present while you treat your patient. Others find it odd for a woman to provide advice and treatment to a man, or for a woman to have bare arms. OTs in a multicultural setting often check with other health professionals who come from the cultural group about the norms within the group. Others ask their patient what is acceptable and what is not.

- Use a translator. You may wish to bring in a translator where language comprehension is an issue. OTs encourage the use of professional translators who are trained to relate every word rather than paraphrase or summarize the conversation. If you are using a family member or friend to translate, they suggest that you coach the person to relate the full words of the patient rather than paraphrasing or summarizing them. OTs who work in environments where many languages are spoken frequently use colleagues to translate when translators are not available, although they ensure that a translator is available for the first meeting.

Warning Signs

- Has a patient's family started to hover when you are visiting a patient?
- Has a patient of the opposite gender begun to view your visits as 'friendly' visits and made advances towards you?

Case Studies: What Would You Do?

Mr. Lam has chronic heart problems. He has been referred by his Doctor for instruction on energy conservation. You want to observe his activity level. Mr. Lam readily agrees to the assessment but you have a sense that he does not really understand what this has to do with his heart. On the other hand, he will do whatever you say and you are in a hurry. What do you do?

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Joe, a male occupational therapist working in a hospital setting, was about to instruct elderly Mrs. Jones in toileting techniques. He sensed that she was very uncomfortable being instructed by a young man. What should he do?

Guideline 4: Preparing for the Meeting

Advance preparation for your meeting with the patient allows you to plan to avoid the risk of potential boundary violations.

THE GUIDELINE

Where possible, gather information in advance on the patient's needs, cultural background, the setting for the meeting and particular challenges in the situation. Choose a neutral setting and explain the purpose of the meeting. Arrangements which are open and above board are less likely to be misinterpreted.

Some Basic Tips and Hints

- Gather information through a review of the patient's file and/or charts or by talking with the referring party where possible.

When you review the file or chart, look for:

- Indications of cultural background so you can ensure that you are sensitive to your patient's cultural needs. For example, some cultures regard bare arms as highly suggestive.
- Cognitive level. Patients with special cognitive needs present with specific communication needs.
- Background reasons for the assessment or visit. These reasons may affect the patient's reaction to your visit. For example, an occupational therapist visiting to complete an assessment for insurance purposes might be seen as wielding extensive power over the patient.

Choose a neutral site for your meeting, to ensure that the purpose of the meeting is clear. For example, rather than meeting in a one-room setting, your first choice might be to arrange to meet in a public location, such as a coffee shop. In a home, choose a neutral spot – one which is normal for new visitors.

In order to protect both your patient and yourself, if you are concerned that a situation might be misinterpreted, **set up backup systems**. These systems keep the tone of the meeting businesslike and focused. For example:

- Ensure that your office knows where you are.
- Set the time of your meeting appropriately to avoid giving misleading signals to the patient.
- When a meeting will be held after office hours, arrange to have others on the premises during the time of your meeting. For example, one unit arranges to have a second staff member on the clinical premises during after hours meetings.
- Send a letter in advance to the client outlining the purpose of your home visit.

Warning Signs

- Are you meeting a patient regularly in a setting which might lead to misunderstandings?
- Do you often find yourself being surprised by a difficult setting or an unforeseen issue?

Case Studies: What would you do?

No file was available for the occupational therapist to review when she was assigned by her employer to visit a new patient to complete an assessment. When she arrived at the patient's home, she found that it was a single room in a rooming house. The patient was sitting on his bed and the only place for her to sit was on the patient's bed as well. The patient patted the bed beside him expecting her to sit down. What should she do?

Guideline 5: Professional Presentation

THE GUIDELINE

Your presentation (manner and appearance) should reflect you as the professional you are. Inappropriate presentation may lead to your intent being misinterpreted.

Some Basic Tips and Hints

The following suggestions represent a quick refresher:

- You can set a professional, businesslike tone for the meeting by introducing yourself and your business role, presenting a business card, and describing the agenda for the meeting.
- Maintaining a businesslike approach and sticking to the purpose for the meeting avoids giving the wrong impression to the patient. Patients like to share information about their life with you and may want to know something about you. People in the helping professions want to be liked, so may spend inappropriate amounts of time on non-essential topics of conversation. While it is important to establish rapport, it is equally important to keep the discussion on track and focused on the patient.
- Dress professionally, in clothing which is consistent with the setting, appropriate to your task and not suggestive or likely to be revealing, to maintain the businesslike tone. Clothing with flowing sleeves or long hair which might brush against a patient's body during treatment might be interpreted as inviting a response.
- If your patient is inappropriately dressed, you might ask the patient to take a moment or two to change. Although courteous about your request, it is important to ensure that no misunderstandings exist about the business nature of the meeting. Some OTs suggested saying, "Oh, I'm sorry I arrived before you had a chance to dress. I will be glad to wait while you change into your daytime clothing."

Warning Signs

- Have you found yourself in situations where a patient compliments you on your attire and believes that you have dressed especially well to visit him / her?
- Has a patient had an inappropriate sexual response during your meeting? Sometimes this cannot be avoided because of the patient's condition, but perhaps the patient has misinterpreted something which has occurred.
- Are you dressing especially carefully and attractively to visit some patients?
- Are you wearing clothing to work that you would wear on an important date?

Case Studies: What would you do?

Sue's patient is a gruff, difficult individual. At a recent visit, he was dressed in a housecoat. When he sat in a chair, the housecoat swung open to reveal that he had no clothing on underneath. Sue suggested that he change but he said he was quite comfortable. How should Sue handle this situation?

Guideline 6: Effective Communication

The best way to prevent boundary violations is through effective communication. By ensuring that your patients and, where appropriate, their families, correctly understand, you prevent the potential misinterpretation of your words and actions.

The basic guidelines of effective communication are listed below. Ensuring that you practise effective communication plays a critical role in preventing allegations of sexual abuse.

THE GUIDELINE

- i) The content of effective communication maintains professional boundaries.
- ii) Effective communication is clear and to the point.
- iii) Effective communication reinforces the patient's understanding. It ensures that the patient understands what is to be done, and the reasons for the assessment or procedure, then reinforces the message throughout the meeting and summarizes at the meeting's conclusion
- iv) Effective communication 'checks back' with the patient for understanding.
- v) Effective communication ensures that your words, tone of voice and body language are consistent with the message you want to convey.
- vi) Effective communication is tailored to the needs of the patient.
- vii) Effective communication listens for the unspoken message. Your listener evaluates your message against his/her experiences and feelings about what has happened to him/her in the past. Effective communication means listening for your patient's unspoken concerns and issues.

Some Basic Tips and Hints

The content of effective communication maintains professional boundaries.

- Nothing more invites misinterpretation and misunderstanding of intent than the crossing of professional boundaries during conversations with a patient. A good guideline for content is to ensure that the conversation is strictly focused on matters which are related to the assessment or treatment of the patient.
- The 'therapeutic use of self' is an important tool, but it is important not to cross boundaries into excessive disclosure which could lead the patient to believe that you want a personal relationship. Most therapists suggested using general examples rather than specific ones to avoid excessive disclosure.
- Areas of excessive disclosure would include discussion of your personal issues, such as your relationships with others, and discussion of the patient's personal issues unless they are related to the therapy underway. Disclosure of seemingly innocuous details, such as your birth date, may lead to difficulties in the future.
- Avoid discussing the patient's body or presentation, except in medical and appropriate professional terms where the discussion is strictly related to the assessment or treatment.

Effective communication is clear and to the point.

- Explain each step and action clearly. It is essential to be very concrete and leave nothing to the imagination.
- When the patient acts in an inappropriate way, you should explain immediately and clearly what the unacceptable behaviour was and what action would be better.
- Patients may mistake the professional caring and attentiveness of a therapist to mean that the therapist wishes to become a personal friend. Building a relationship with the patient is very important for success, but it is the responsibility of the occupational therapist to establish and maintain the professional relationship. For example, a long-term mentally ill patient of one OT described her repeatedly as his 'friend'. Concerned that he was misunderstanding the professional relationship, she described herself as his 'therapeutic friend' – a definition he happily accepted and used.

Effective communication reinforces the patient's understanding. It ensures that the patient understands what is to be done and the reasons for the assessment or procedure, then reinforces the message throughout the meeting, summarizing at the meeting's conclusion.

- Explain the assessments or procedures well in advance. When possible, many OTs explain the assessments and procedures at the first meeting and complete the assessments at later meetings. They start with basic issues and move to more sensitive topics later in the meeting or at subsequent meetings.
- Explain how the assessment or procedure will benefit the patient. For example, "I would like to see how well you are doing dressing yourself because we may be able to find a way to help you do it more easily."
- Continue a step by step description of what and why throughout the assessment or treatment. This is particularly important when you are orienting or instructing the parent or responsible relative of a patient.
- When you have concluded your visit, ensure that you summarize what has been done and the patient's ongoing responsibility (including instruction sheets where possible).

Effective communication 'checks back' for understanding.

- Ask the patient to 'play back' his / her understanding of what will be happening and why. This is a wise precaution in any event, and particularly important with brain-injured or cognitively-impaired patients.
- Often therapists ask whether the patient is comfortable with the assessments and procedures which have been proposed.

Effective communication ensures that the words, tone of voice and body language of the therapist are consistent with the message she/he wants to convey.

- In 1968, psychologist Albert Mehrabian noted that only 7% of the message received by the listener is derived from the words, while 38% is drawn from tone of voice and 55% from body language. (Psychology Today, September 1968, p.53).
- Effective communicators avoid misunderstandings by ensuring that their message, tone of voice, and body language are consistent. If your words are businesslike, but your tone of voice or body language is not, then your listener may be confused about your real message. Allegations of abuse may result from this inconsistency.

Effective communication is tailored to the needs of the patient.

It recognizes diverse needs.

- Do an 'on the spot' evaluation of the level of understanding of the patient, and adapt your style and communication level to the needs of the patient.
- Your patient is your partner in the communication process. Often, in the stress of the moment, patients or parents of patients don't remember what was advised during your meeting.
- A number of strategies can be adopted to prompt information retention:
 - Leave a note or instruction sheet describing what will take place at the next meeting and/or
 - Explain the procedure again at your next meeting.
 - Ask if the patient would like a family member or friend to be present while you explain the assessments or procedures.

These steps ensure that the intent and purpose of your words and actions can be reviewed and made clear following the meeting.
- Ensure that you speak to the patient directly, even when a family member is present. One therapist spent an entire meeting speaking with the daughter of an elderly patient, only to find out that the patient was extremely angry because she felt she had been excluded from the discussion.
- When dealing with children, ensure that the parent becomes part of the therapy by informing and involving the parent at every step.
- With patients who are mentally ill or cognitively impaired, therapists ensure that their communication is exceptionally clear and concrete, using short sentences and words.

Effective communication listens for the unspoken message. Your listener evaluates your message against his/her experiences and feelings about what has happened to him/her in the past. Effective communication means listening for unspoken concerns and issues.

When a therapist is talking with a patient, at least three conversations are going on:

- the conversation between the therapist and the patient and,
- the internal conversation within the patient, and
- the internal conversation within the therapist.

Each person's internal conversation checks the incoming information against all of the experiences and feelings the person has had in the past. When the relevant experiences and feelings are positive, the incoming information will be viewed positively. When the experiences have been negative, the incoming information will be assessed with a negative filter. Sensitivity to the prior experiences of the patient will help the therapist ensure that words and actions are not misunderstood. When the response from your listener is not what you might have expected, check with him/her to find out what the concern is.

A patient may draw back from an assessment or procedure. Ensure that you stop immediately, move to 'safer' surroundings if necessary (for example, if you were doing an assessment on the person's ability to get into and out of bed, you would move to the kitchen or the living room), and inquire whether the person has any concerns. For example, "Mr. Jones, you seemed to feel uncomfortable with doing the assessment of how well you get into or out of bed. Do you have a concern with doing this? Could you help me understand?"

Warning Signs

- Has a patient shown reluctance to participate in an assessment or procedure that he or she has previously agreed to? This may be an indication that the patient did not truly understand what would happen and why.
- Are there signs that a family member is pressuring the patient to participate in the assessment or procedure?
- Do you want patients to ask how you are?
- Do you share personal information with your patients?

Case Studies: What Would You Do?

84-year-old Mrs. Alexandre lives alone and, on occasion, is quite confused. During the last visit, when you explained that you would be doing a dressing assessment she understood and agreed. Today, however, she seems to hardly remember you and, when you explained the procedure again, she was not sure she wanted to participate. What should you do?

—

One therapist was told by the mother of the baby she was treating that the previous therapist had not 'handled' the baby correctly. What should she do?

—

You are a therapist working in a hospital setting. Yesterday, when you happened to be in a patient's room, you overheard a member of another regulated health care profession making a remark to a patient about how nicely her breasts are shaped and that, 'with her nice body', she would be getting lots of dates any time soon. What should you do?

Case Examples: The Recommendations of Experienced Occupational Therapists

With all of the above case examples, knowledge of the context of the situation would assist in making the correct decision. These have been chosen to illustrate some key issues in setting and maintaining boundaries.

Guideline 1: Practice Situations

On Joanne's third visit to a male patient, he asked her to demonstrate for him how he should masturbate. What should she do?

Joanne should reassure that this area of sexual behaviour may be very important to him. However, it is not part of the occupational therapist's role to demonstrate masturbation. She could provide him with a tape he could view within the privacy of his own home and/or she could refer him to a sexuality clinic. She could also suggest that he talk to his doctor or to a trusted male relative. Joanne must ensure that she documents the incident.

When Mary was demonstrating personal dressing techniques to a male patient, he seized her and gave her a passionate kiss. What should she do now? What should she do to prevent this in the future?

Mary should immediately remind the patient that the kiss was inappropriate.

Clearly, however, this is a patient whose needs are leading to inappropriate behaviour. She might encourage him to talk about his needs and suggest that she can refer him to someone who could help him deal with his need for intimacy. If it should happen again she should refer his case to another therapist. Again, she should ensure that she documents the situation.

Guideline 2: Risk Management

A confused elderly male patient, being treated at his home, became convinced that John, the male therapist, was 'coming on' to him. The patient repeatedly told his family that he was concerned for his safety with the therapist. A family member came to John to relate the story and ask what to do. What should John do?

First, John should find out the circumstances (assistance with ADL, transfers, bathing) which led the patient to conclude that John was 'coming on' to him.

John could invite a family member to be present during treatment so that John could explain why he was touching the patient in certain areas. The family member could provide treatment after he has trained them in the procedures.

As an alternative, John could recommend a change of therapists. Again, John should ensure that he documents the situation.

Note that it is important not to be patronizing or sound cross. Maintaining your professional presence in this type of situation and ensuring that you educate the family to ensure that they understand and reduce their anxiety is essential.

Susan has been providing service to a young child injured in a car accident in which the mother died. The father has been very grateful for her help and has sought her advice on quite a number of parenting and other issues. At this visit, he asked Susan to go to dinner with him. She would really like to accept. How should Susan handle this situation?

Susan needs to ensure that the father understands her role. She should remind him that, as she is still working on the case, she must refuse his kind offer of dinner. To ease his feelings, she might point out that it is not that she does not like him as the caring father of a patient, but that it is an ethical matter. In addition, she could note that it is the policy of the agency not to accept these kinds of gifts.

She might redirect his gratitude by indicating that there is a fund at the agency to which he could contribute that would benefit all staff or that a note to her supervisor stating how much he has appreciated her specific help would be very supportive.

Jane had been the case manager for a male patient for quite a lengthy period of time. On her birthday, when Jane arrived at her male patient's apartment for a meeting, she was presented with a dozen red roses 'for her birthday'. What should she do?

Jane has reason to be concerned, because the patient may be confusing her normal kindness with a specific interest in him. She needs to ensure that he understands the patient / therapist relationship while not hurting his feelings.

She could say she is taking the bouquet back to the office to be shared with all the staff.

She should remind the patient that gifts are neither necessary nor expected, but that she appreciates his thoughtfulness. She might then refuse to take the bouquet, saying that the agency has a policy against the acceptance of gifts.

If she is married or in a relationship, she should ensure that the patient knows that she has other interests.

Guideline 3: Diversity

Mr. Lam has chronic heart problems. He has been referred by his Doctor for instruction on energy conservation. You want to observe his activity level. Mr. Lam readily agrees to the assessment but you have a sense that he does not really understand what this has to do with his heart. On the other hand, he will do whatever you say and you are in a hurry.

What do you do?

If there is a family member there, you might use them to help Mr. Lam understand, since it is important that you only proceed if Mr. Lam understands. If you conclude that he does not understand, you could explain and provide visual educational material to be reviewed before another visit. At the next appointment, you should ensure that an interpreter or a family member who can interpret will be present to help explain the assessment.

Joe, a male occupational therapist working in a hospital setting, was about to instruct elderly Mrs. Jones in toileting techniques. He sensed that she was very uncomfortable being instructed by a young man. What should he do?

He can ask Mrs. Jones if she does feel uncomfortable having him help her and if she would feel better if someone else were to help her. During this conversation he might ensure that Mrs. Jones is aware of his professional approach. If she is uncomfortable, he might ensure that another therapist assists her in the future.

Guideline 4: Preparing for the Meeting

No file was available for the occupational therapist to review when she was assigned by her employer to visit a new patient to complete an assessment. When she arrived at the patient's home, she found that it was a single room in a rooming house. The patient was sitting on his bed and that the only place for her to sit was on the patient's bed as well. The patient patted the bed beside him expecting her to sit down. What should she do?

The key element is that the occupational therapist should not sit on the patient's bed, since this action is open to misinterpretation. The OT could:

- Look around neighbouring areas to see if she can find a chair
- Stand in the room
- Ask if there is another area where they could meet, such as a common room, kitchen, or office
- Reschedule and make the next appointment for a more neutral location.

Guideline 5: Professional Presentation

Sue's patient is a gruff, difficult individual. At a recent visit, he was dressed in a housecoat. When he sat in a chair, the housecoat swung open to reveal that he had no clothing on underneath. Sue suggested that he change but he said he was quite comfortable. How should Sue handle this situation?

Context is especially important here. Sue's patient may have difficulty dressing, be sore and stiff with arthritis, have an intention tremor with M.S. or be confused. However, whatever the context, it is important that this patient learn that this is not appropriate and that he must be dressed in the future.

The therapist might:

- Say she needs to see how the patient manages in getting dressed (depending on the reason for the visit).
- Say that she would feel more comfortable if he was dressed and that she will wait while he does this.
- Ask if he has medication that he is required to take and check to see if he has taken it. If medication has been skipped, this might account for the behaviour.
- If the patient totally refuses to dress, make a note of the situation and let him know that she cannot continue with the visit. Make an appointment to come back at a later time, when the patient is dressed.

Sue should ensure that she documents this behaviour.

Guideline 6: Effective Communication

84 year old Mrs. Alexandre lives alone and, on occasion, is quite confused. During the last visit, when you explained that you would be doing a dressing assessment she understood and agreed. Today, however, she seems to hardly remember you and, when you explained the procedure again, she was not sure she wanted to participate. What should you do?

Context is very important, but having completed the preparation thoroughly, the therapist would be well aware of the reason for Mrs. Alexandre's confusion.

You could:

- Reassure her that, since she does not want to go over dressing with you, you will see her another time. Ensure that you do not patronize her or talk down to her, since this will emerge in your voice and Mrs. Alexandre will be alienated.
- If she is dressed when you visit, then you could find out if she did this on her own. If she had help, who helped her? This person might be an ally to assist you.
- Whether she is at home with family, or on a ward, you could find out when she normally gets dressed and schedule your visit for that time.
- If this is too distressing for Mrs. Alexandre, you could finish the involvement and/or make other arrangements for help for her.

One therapist was told by the mother of the baby she was treating that the previous therapist had not 'handled' the baby correctly . What should she do?

The therapist should discuss with the mother what she meant by this comment and ask the mother to elaborate. If the actions constitute sexual abuse, the occupational therapist must report the therapist to his/her professional College.

You are a therapist working in a hospital setting. Yesterday, when you happened to be in a patient's room, you overheard a member of another regulated health care profession making a remark to a patient about how nicely her breasts are shaped and that, 'with her nice body', she would be getting lots of dates any time soon. What should you do?

You are legally obligated to report this to the regulated health care professional's College. Failure to do so could jeopardize you.

Definitions

Throughout this Guidebook, certain terms are used with the following meanings:

'Registrant' is interpreted to mean 'member' of the College.

'Patient' is used because this is the terminology used in the RHPA. It is a more precise term than 'client', although many people use the terms interchangeably. The patient is the recipient of direct occupational therapy care. If the primary patient is a child, the child's parent may be a patient, too.

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