Boundaries and Ethics

(Alternative version of an invited chapter for an upcoming anthology on complex trauma in youth)

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Abstract

This chapter reviews professional boundaries and ethics in work with adolescents who have experienced complex trauma. It explores definitions and key points in treating complex trauma. It begins with a case illustration highlighting the difficulties involved in complex trauma and how challenges in this area can be different from other areas of therapeutic endeavor. It next provides an overview of ethics and boundaries, with case examples throughout. It then reviews four primary ethical foundations: beneficence, autonomy, justice, and nonmaleficence in depth and provides steps for professionals to take in ethical decision-making. It then reviews how approaches such as Motivational Interviewing and Feedback-Informed Treatment can help professionals adhere to these principles. The chapter concludes with an exercise on "going upstream" from a given symptom or behavior to what is meaningful and relevant to the client, thus supporting ethical practice. It ends with a brief thought exercise/meditation on exploring one's own boundaries in the service of helping others.

Introduction

Boundaries and ethics play an important role in understanding, assessing, and treating individuals with histories of complex trauma. This chapter argues that in order to best serve people with histories of severe and repeated trauma, professionals[1] need to look beyond the language of the existing ethical codes of professional organizations and examine how best to maintain the highest standards of behavior with clients who have historically been treated unethically (at best) and had their boundaries violated.

It may help to start with an illustration[2] of how boundary crossings and violations may occur under common circumstances. From there, practitioners should consider ethics and boundaries as they apply in the therapeutic relationship.

Illustration

Darnell, a clinician of several years' experience, participated in implementing an empirically supported treatment model for treating trauma. The implementation project was stringent, involving several days of training and several months of periodic fidelity monitoring. The larger project reflected a statewide attempt to provide trauma-informed care to adolescents who were under the supervision of the state's Department of Corrections (DOC). Of note was that the treatment method itself had been developed and found to be effective with a different population (adult females) than it where it was now being applied (adolescent males and females).

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[1] Because this chapter is intended to be relevant for all who work in the helping professionals, it uses the term "professionals." This term includes people with backgrounds in psychology, social work, counseling, administration, education, and criminal justice.

[2] All cases have been modified to protect the privacy and confidentiality of everyone involved.

In order to ensure that clinicians practiced with fidelity to the model, each session was recorded on video. The camera would be focused on the clinician and not the client, and the recordings were confined to a secured information channel. Under these conditions, it seemed that little could go wrong. From the perspective of the developers, their consultant/trainer, and administrators at the DOC, the primary threat to the model's fidelity was the clinicians administering it. Like countless others involved in implementation, they had experienced situations where clinicians strayed from the manual and improvised in sessions, thereby potentially undermining the treatment fidelity. During the training, and in subsequent consultation calls with the clinicians, the consultant/trainer and developers emphasized the importance of taking no liberties with the curriculum and recording each session.

Darnell scheduled a first session with a transgender adolescent male with a horrific history of sexual abuse, Sam, who had recently been adjudicated by the court for a drug offense. Darnell explained the video-recording process and that a review team would be assessing his work and nothing having to do with Sam, who responded immediately with, "Yes, I'll be happy do that for you." Darnell thanked Sam and explained it wouldn't be necessary after all. They completed the first session with little difficulty.

Darnell called his supervisor after the session: "I know that everyone wants every session recorded," he said. "Please try to understand; this is a kid whose entire survival has depended on making adults happy. He goes along with what adults want from him because when he was younger it would have been much worse for him if he didn't. This wasn't informed consent; it was a symptom of the very trauma I was trying to help with. I couldn't in good conscience go forward, even though he appeared to be consenting." The supervisor understood and said she would handle the inevitable fallout from those in charge of the implementation. The fallout that did occur took the form of warnings: "Yes, we understand, and it was the right decision. However, don't forget that we've seen our share of clinicians who didn't want to submit videos, so our expectation is that this won't happen again." The dynamics left the treatment team on edge and worried about the possible consequences of standing up to the consultant and DOC administration again.

Perhaps the biggest lesson from this situation is how nuanced working with complex trauma can be. Understanding how abuse dynamics might play out in very subtle ways, as Darnell did, is an important first step. Ultimately, among the most effective questions professionals can ask is whether – and how – a given action is in a client's short- and long-term best interests, or whether the action considered serves the needs of others.

Other questions arise from this situation as well. Among them are:

What considerations should practitioners give when applying a method or model developed for one population to a different demographic? In this case, the model was developed and validated with adults and was now being used with adolescents. In what ways might this practice resemble the off-label use of medications?

What dual relationships exist when a large agency such as the DOC (or for that matter, child welfare or a school department) essentially mandates a treatment? In this instance, the DOC

administration's motivation was based on the realization that people who come under their supervision have typically experienced trauma. However, the DOC, like other agencies, holds considerable power over its charges. To what extent does a referral to treatment appear as a demand to participate against one's will? Where does informed consent begin and end under these circumstances? Taking this point a step further, what are the ethics of assigning a single, specific treatment to a client without discussing other options?

A central challenge for practitioners, one that may not be apparent in a cursory review of the codes of ethics of the helping professions, is the lived experience of our clients, which has too often translated as, "You must, or I'll hurt you." Just as no one has the right to say this to others, our clients' experiences remind us that a primary obligation that practitioners have is to refrain from replicating this dynamic and the environments in which it has appeared.

What are ethics?

Definitions of, and reasons for adopting codes of ethics has received considerable attention elsewhere in the literature (e.g., Pope et al., 2021) and require little further discussion here. Codes of ethics exist in numerous areas of professional practice, including doctors, nurses, social workers, psychologists, and certified counselors. As of 2008, 25 states have required ongoing training in boundaries and ethics as part of professionals' license renewals (ASWB, 2008).

In a recent paper, Watts (2021) focused on the elements that make ethics training more and less effective, including areas such as knowledge of ethics and practical application of ethical decision-making. Training in ethics itself presents a dilemma: On one hand, this author is aware of little if any evidence concluding that ongoing training in ethics for the purpose of license renewal actually improves the behavior of trainees. On the other hand, it seems unconscionable not to maintain an ongoing focus on ethics as a subject of professional attention. In the end, adhering to codes of ethics protects both the client and professional alike. The client is protected from harm or exploitation while the professional is protected from even the appearance of causing harm.

In the author's experience, definitions of ethics for various professions have centered on the moral correctness of professional conduct, with the intention of doing no harm, and performing one's work in the spirit of justice. Sawyer and Prescott (2010) noted that professional ethics are typically founded on underlying values such as:

- Clients are, by definition, vulnerable when receiving mental health services.
- Professionals have varying degrees of perceived or real power and authority (and this is especially true when clients are mandated by the courts or social service agencies into treatment).
- There is an essential need for physical and psychological safety for clients who receive mental health services. (p. 2)

Likewise, Sawyer & Prescott (2010) also noted that common elements of ethical codes include:

- upholding the dignity of the person

- avoiding discrimination
- preventing harm
- informed consent
- preventing conflicts of interest
- avoiding multiple or dual relationships
- engaging in no sexual or relationships or intimacies
- engaging in no sexual harassment
- protecting privacy
- refraining from unnecessary physical contact

In recent years, professional organizations such as the American Psychological Association and the National Association of Social Workers have added professional self-care to discussions of ethical considerations (e.g., Abramson, 2021). While it may seem sad that this needs to be codified, its importance in effective mental health practice should be obvious. When professionals are not rested and at peace with themselves, clients may suffer the consequences, particularly those with histories of complex trauma. A client of another therapist recently shared with the author that there are several areas of her life that she does not share with her therapist, since that person already has lots happening in her own life and my friend doesn't want to upset her further.

What are boundaries?

"Boundaries" are the structural and interpersonal aspects of a relationship that make therapy possible. It is always the responsibility of the professional to ensure that boundaries are clear. Structural boundaries include considerations such as clarity and agreement about the time and place that services take place; interpersonal boundaries include the limits of relationships, such as gift-giving, explicit expectations that there will be no sexual contact, and agreement on the nature of any physical contact (such as handshakes, fist bumps, occasional pats on the shoulder), all depending on the circumstances in which treatment takes place.

At their core, effective interpersonal and professional boundaries leave each person feeling *protected* and *connected*. Although these are simple enough to describe, questions and seemingly unpredictable answers can arise quickly. For example:

A therapist working with a client to explore soothing music to assist in self-regulation finds that the client also has extensive knowledge of 1970s rock bands. Acknowledging their share interest could potentially help their mutual understanding of each other. However, the treatment setting is inpatient, and other clients might view an interest in this music as an indicator that the therapist used drugs in the past.

A therapist in the same inpatient treatment setting elects not to wear a wedding ring because he wishes to protect his privacy. In this setting, the direct care staff freely share their relationship status. Questions arise as to whether this should be a personal decision or if the administration should develop a policy so that no one is placed in an awkward situation.

The answers to these questions can often be answered by exploring what is in the clients' *long-term* best interests. In the first example, there are other ways to forge a strong therapeutic alliance that don't hinge on risky personal disclosures. In the second example, the concern might best be addressed by providing guidance to all employees about how to respond to personal questions in a manner that leaves clients feeling protected and connected.

Why should we care?

In a classic article on professional boundaries, Smith and Fitzpatrick (1995) emphasized the need for professionals to *abstaining from personal gain, remaining neutral, and fostering independence and autonomy*. Certainly, the first of these, abstaining from personal gain, can be relatively easy to accomplish with firm structural boundaries around events such as gift-giving or avoiding dual relationships. Professionals will occasionally need to be on guard against interpersonal gain, such as receiving gratification from being an important person in the life of the client or viewing themselves as akin to a savior when helping a client to exit an abusive relationship.

The second of the above the above principles, neutrality, can also be accomplished under other circumstances. However, professionals will want to be on guard against interpersonal values, attitudes, and beliefs from entering the therapeutic arena. It has long been noted by professionals that traumatized people can have an eerily accurate sixth sense about what people around them may be thinking or feeling. It is not uncommon for professionals to have attitudes and beliefs that they refrain from sharing with clients. In fact, many professionals have attempted to appear neutral in discussing a client's relationship while secretly thinking to themselves, "Leave him! Leave him now! He's obviously no good for you and could become violent again with the least provocation." Unfortunately, clients with histories of complex trauma can often sense that the person they are talking to is thinking things that are different from what they are saying and can be acutely sensitive to indications that the professional is not saying what they are really thinking. This can be highly unnerving for the client and professional alike, since it can sometimes replicate the environments in which abuse occurred (for example, the home where everyone knew that abuse occurred, but no one dared to talk about it).

It can be useful for professionals to consider their own values, attitudes, and beliefs outside of sessions by exploring hypothetical situations. Given that professionals are expected to be neutral unless there are compelling reasons not to be (for example, when dealing with client disclosures that require a mandatory report to a child protective services agency), here is a sample of possible situations to consider the bounds of neutrality:

- An adolescent female with a history of complex trauma enters treatment and is considering her options for further education and a career. Do you have a strong opinion about this? On its surface, it seems to be a deeply personal decision that only she can make; you may have a role in helping her to clarify their decision.

- A young man turning 18 who was abused by his older brother on multiple occasions was often protected by their older sister. He has long been very grateful to her. His sister now needs a kidney donation, and he is considering being the donor. Where might you stand

with respect to neutrality in this situation? You may feel an obligation to explore the client's motivations to make sure that he is clear on his own motivations and ready, willing, and able to become the donor?

- A person who was abused by their father is considering confronting them and informing other members of the family who may not know. You may have a strong opinion and be tempted to directly advise the client based on what you know about their experiences. While staying grounded in the principle of neutrality, however, it would likely be more effective to explore the pros and cons of such actions and help them to make their own informed decision.

- An adolescent male in treatment is considering going to the home of the teacher who had sexually abused him two years earlier. He wants to confront the man with the man's wife present, and this may involve knocking on the door and forcing his way in if the man doesn't want to let him in. The client has not stated an intention to become violent, but you are of the opinion that someone could get hurt. In what ways do you maintain neutrality? As in the earlier example, perhaps you explore the pros and cons of this action and ask him about the potential consequences to himself as well as others?

- A young woman with a severe history of trauma as a child discloses that she has been experimenting with heroin. Where does neutrality begin and end in this situation?

Some of these scenarios are more difficult than others, mirroring the decisions professionals must make in mental health settings. For professionals providing direct services, the temptation to fix clients' problems and provide solutions can be very strong. This can easily lead to bypassing professional neutrality along the way.

The examples provided immediately above also speak to the third principle discussed by Smith and Fitzpatrick (1995), that of *independence and autonomy*. This principle is particularly important, since so much of what constitutes trauma involves violating another's independence and autonomy. It can be easy to think of independence and autonomy as it pertains to broader life issues, such as changes in relationship status (e.g., supporting the person who is leaving an abusive marriage), supporting a client's efforts to pursue gender-affirming care, or helping the client who has been molested by a family member to live free and apart from those who harmed them. Of course, for clients with histories of complex trauma, questions of independence and autonomy can surface in the daily routines of life. Deciding what to eat, what to wear, and when to do which activity can take on a special meaning for each client.

For these reasons, supporting client independence and autonomy should be at the top of every professional's mind. Examples from the author's practice (in primarily inpatient treatment settings) of how well-intended professionals can do harm have included:

- "With your trauma history, you really need to do [a specific form of trauma therapy]," without discussion of what type of therapeutic work the client would find helpful.

- “I can make a referral to your medication prescriber, but I can tell you that you’ll need to be on those medications for the rest of your life. They’re helping you to manage your behavior.”

- “We’re here to work on your trauma and here’s how we’re going to deal with it.”

On the other hand, a psychologist colleague outside the US was once asked to conduct an evaluation on an Indigenous adolescent who had just been arrested. He had a long history of abuse and neglect, all in the context of massive cultural trauma. He was on probation and one evening while his mother was drunk at home, she told him to go to a nearby pub to borrow money to buy more alcohol. He was arrested for a violation of his community supervision rules as he left the pub and headed home. The psychologist, feeling that the arrest was itself unjust, decided that she could at least give the young client every opportunity to explain who he was and why he did what he did so that she could write the fairest report for the court. She later said, “Given how counter-therapeutic the entire situation was, I could at least be the professional who offered a choice when all other choices had been taken away.”

While the three principles set forward by Smith and Fitzpatrick (1995) are of obvious importance, several other considerations fall outside their bounds. The first is the obligation to impart accurate information. On more than one occasion, the author has heard professionals state to the client or in their presence that they have been “scarred for life” by the abuse they have suffered. Often, this has happened in the context of clients testifying in cases against the people who abused them. While there is no question that traumatized people often carry the physical and metaphorical scars of their victimization for the rest of their lives (and most of them are all too aware of this without being reminded), it is also true that a significant number of those who survive complex traumas can rebuild their lives (Fuller-Thompson, 2016). There can be an unintended, iatrogenic effect from telling someone that they are scarred for life. Ethical and boundary concerns follow when we tell someone, potentially very inaccurately, that they are the one thing they don’t want them to be.

A final boundary consideration that has received very little discussion has to do with empathy, validation, and shame. It is well established in clinical research that empathy is a central feature of any effective therapy or therapist (Moyers & Miller, 2013). However, in working with clients with histories of complex trauma, it can be vital to remember that empathy has often been weaponized against them. Often, this has taken the form of someone using knowledge of their vulnerabilities against them. This is not an entirely new idea; it’s long been known that the most effective hunters are those who can understand and predict the internal mindset of their prey. Likewise, truly sadistic individuals can inflict additional harm because of their understanding of the inner world of the people they victimize. As a result, professionals need to be cautious in how they use empathy. Too much can replicate abusive environments where the client’s needs for connection and coregulation were never met; too much empathy at once may leave clients exposed and vulnerable. As commonly occurs with therapeutic processes, there is no single way to balance the amount of empathy expressed, and the most effective way to ensure one isn’t having a negative effect is to check in with the client directly and frequently. Further suggestions are provided below.

Boundary crossings

Sawyer and Prescott (2010), Smith & Fitzpatrick (1995), and others have distinguished between *boundary crossings* and *boundary violations*. The former describes departures from common practice that may or may not benefit the client. Professionals working with groups of adolescents, for example, might occasionally bring in snacks knowing that offerings of food are a nearly universal signal of goodwill and that adolescents who have had a snack can often focus better within treatment sessions. In other settings, this would not be considered acceptable. Boundary violations, on the other hand, are departures from accepted practices that pose an unacceptable risk to the client or therapeutic processes.

Pope and Keith-Spiegel (2008) identified seven cognitive errors by clinicians that can contribute to boundary crossings and violations:

- Error #1: What happens outside the psychotherapy session has nothing to do with the therapy.
- Error #2: Crossing a boundary with a therapy client has the same meaning as doing the same thing with someone who is not a client.
- Error #3: Our understanding of a boundary crossing is also the client's understanding of the boundary crossing.
- Error #4: A boundary crossing that is therapeutic for one client will also be therapeutic for another client.
- Error #5: A boundary crossing is a static, isolated event.
- Error #6: If we ourselves don't see any self-interest, problems, conflicts of interest, unintended consequences, major risks, or potential downsides to crossing a particular boundary, then there aren't any.
- Error #7: Self-disclosure is, per se, always therapeutic because it shows authenticity, transparency, and trust.

These can serve as a useful checklist for professionals engaged in the day-to-day work of tailoring their treatment approach to meet the needs of their clients.

Considerations for paraprofessionals

A couple of additional points are worth considering for those engaged in residential/group care, case managers, etc.

First, although it might seem obvious, it is worth remembering as well as training and re-training staff that any form of sexual behavior with clients is unethical and non-consensual by nature. It is illegal and will always be harmful to clients who are entrusted to the care of others. There are no exceptions to this. It is particularly important to note in adolescent complex trauma cases because clients in group care can often behave differently from other teens. Male staff might perceive a female client acting in a seemingly seductive fashion. Should staff members believe that a client is flirting with them, it is imperative to view this as a trauma symptom. The behaviors that seem flirtatious can, in fact, be a strategy for survival; in essence, the adolescent is testing the staff member as if to say, "Let's see how you behave when I flirt with you. If you flirt

back or otherwise approach me, I will know that you can't be trusted." In some cases, flirtation may occur because it is the only way that a traumatized client knows how to interact with adults, primarily men, who hold power and authority over them. Maintaining professional boundaries in the face of this interactive style is fundamental to preventing harm to both clients and the adults who care for them.

Second, it is often crucial to remember that hypervigilance and being quick to anger are primary survival skills for children and teens with histories of complex trauma. In fact, fighting back against power and authority has often served them well in the past, no matter how much it appears inappropriate outside of the abusive environments they've endured. The most ethical and effective approach is to stay within boundaries marked by a calm and soothing approach. When a client becomes irate, moving closer to them (as if preparing to take physical action) or raising the rate, pitch, or volume of one's speech virtually guarantees re-traumatization for the client. In group care, the most effective front-line staff are those who can always display a calm and soothing demeanor. One residential program for justice-involved youth in the author's experience reduced the number of physical restraints of clients to the extent that they became very rare events. Chief among their techniques was to form a human shield when one resident would attempt to attack another, to prevent both the attack and the staff becoming physically aggressive with traumatized adolescents.

Digging deeper: the "big four" ethical principles

Having examined ethics and boundaries, this section looks deeper at the foundation of ethical and effective professional practice. Varkey (2021) emphasizes four principles that are staples of professional codes of ethics. Although the language can vary from one profession to the next, these are: beneficence, nonmaleficence, autonomy, and justice. Autonomy is discussed earlier and is mentioned again here not for its role in helping professionals stay on track (as above) with best practices. Rather, its role as a fundamental cornerstone of professional ethics serves as a reminder that solo practitioners and agencies alike should maintain an explicit focus on helping clients to achieve autonomy and uphold autonomy at every turn. While most professionals define their work as helping traumatized people to recover, this principle reminds us that *how* we attempt to help is vitally important. Agency policies, interventions, and therapist styles that unnecessarily restrict client autonomy will almost certainly not succeed in the long run.

Autonomy can become complicated when professionals are working with children and teens in the context of their families. Privileging autonomy with young people in a family context can vary from one culture to the next and depend on the constellation of family members. There are no blanket solutions for every case; rather, professionals should actively ask themselves how they can best support each client's autonomy in the circumstances that they exist. Often, this might mean privileging the family's autonomy as well as the individual's. An example of this is provided later in this chapter.

Justice as an ethical principle makes sense and appears completely reasonable. With complex trauma, however, matters become more complicated. Often, children and teens with histories of complex trauma have had direct or indirect involvement with the legal or child welfare systems. Matters can become particularly complicated when the client with complex trauma has close ties

to the person who abused them or others. While many of these situations are addressed in the literature, it can be all too easy for professionals to give the appearance of taking sides and disparaging the person who caused harm unnecessarily or gratuitously.

Obviously, no professionals tolerate abuse or serious wrongdoing by caregivers; framing the message to children and adolescents is important. “Your father is in a place where he will get help and be prevented from harming others” is different from statements indicating that he is a bad person. The first statement upholds justice, while the second may appear to uphold justice, but does so at the expense of supporting the client in autonomously forming their own conclusions about their father. After all, those who abuse have often also been beloved by those whom they hurt and whose conclusions may be complicated. These nuanced boundaries and ethical applications are in no way tolerant of abuse. Instead, professionals can use these principles to form statements and interventions that will be the most beneficial to the client from the greatest number of perspectives over the long term.

Beneficence, being kind, charitable, or benevolent, is a straightforward principle. In the author’s experience, it has been misused primarily in situations where other principles, and even common sense, were not adhered to. In one instance, a detention facility for juveniles experienced considerable difficulties due to its stance on trauma-informed care. Believing that the adolescents in their care were behaving badly due to their trauma histories (which was an accurate appraisal), they elected not to impose any kinds of sanctions on misconduct. The well-intentioned thought was that since this aggression was a trauma symptom, it should be addressed in treatment (also accurate, but insufficient to create a safe environment), and that formal responses to problem behavior should be reserved only for other kinds of clients. Unchecked, these behaviors quickly escalated in this environment, with the result that clients and staff members suffered injury because of escalating violence within an environment which had, ironically, become traumagenic.

In another example, a client with a significant history of complex trauma and an autism spectrum disorder sexually assaulted another client in an adolescent residential program. The supervising clinician, apparently believing himself to be a champion of benevolent approaches, refused to report this incident to the necessary authorities. This was because he believed that the assault was simply symptomatic of complex trauma and autism; as such, it was not like a more volitional assault, which would have required reporting. This person did not remain in their position for long after this, having defied the law and ignored the potential harms to each client as well as the program. While each of the above examples may seem unlikely to happen in one’s own environment, they were the result of seasoned professionals’ actions, taken in the belief that they were upholding beneficence, but ignoring other aspects of professional boundaries and ethics.

The final of the “big four,” nonmaleficence (refraining from causing harm or neglect), may well be the most important. Every professional endorses nonmaleficence, but not all notice when they are engaged in it. In most cases, actions that constitute maleficence are easy to identify. The picture is less clear when complex trauma is involved, as the examples in this chapter show. Rather than review examples, it may be better for professionals to review their practice and ask:

- In what small ways might I be causing harm to clients? This could include anything from disparaging remarks made about family members to the use of sarcasm in one's humor.
- In what small ways might I be neglecting clients? This could include not being fully present in sessions, or not ensuring that one is talking about goals and topics that are personally relevant and meaningful to the client.
- Have I taken any actions in the course of any client's treatment that have served my needs or that of my agency that were not in client's long-term best interests and that might have resulted in harms, no matter how small?
- In what ways might I be engaging in nonmaleficence by not adequately upholding the other "big four" ethical principles in a balanced fashion?

It is worth reiterating that very few professionals don't believe that they live up to these ethical principles. However, the application of these principles requires closer scrutiny when considering children and adolescents with complex trauma, especially when professionals can never entirely know when an action intended to be therapeutic ends up retraumatizing a client. Finally, in cases of complex trauma, the literature, to the author's knowledge, has never discussed the fact that adhering to each of these ethical principles can sometimes require considerable nuance and balance on the part of the professional.

Steps in ethical decision-making

In those moments when professionals, paraprofessionals, and administrators are faced with ethical quandaries, there are few things more helpful than having a checklist to follow. Pope and colleagues (2021) have assembled a list of steps for decision-making that is worth mentioning. Although only summarized here, they have written extensively on this topic:

1. State the question, dilemma, or concern as clearly as possible.
2. Anticipate who will be affected by the decision.
3. Figure out who, if anyone, is the client.
4. Assess whether our areas of competence—and of missing knowledge, skills, experience, or expertise—are a good fit for this situation.
5. Review relevant formal ethical standards.
6. Review relevant legal standards.
7. Review the relevant research and theory.
8. Consider whether personal feelings, biases, or self-interest might affect our ethical judgment.
9. Consider whether social, cultural, religious, or similar factors affect the situation and the search for the best response.
10. Consider consultation.
11. Develop alternative courses of action.
12. Think through the alternative courses of action.
13. Try to adopt the perspective of each person who will be affected.
14. Decide what to do, review or reconsider it, and take action.
15. Document the process and assess the results.
16. Assume personal responsibility for the consequences.
17. Consider implications for preparation, planning, and prevention.

As a case example, let's return to the circumstances of our first illustration in this chapter. In it, Darnell worked as part of a team implementing an empirically supported treatment for trauma as part of a collaboration between his mental health agency and the Department of Corrections (DOC). In this instance, a teenage girl had been referred for treatment by her DOC officer. She vehemently insisted she did not want this treatment and told her probation officer, who suggested she talk with Darnell. However, when she spoke with her parents, they were adamant that she should stay in treatment because this was a condition of her probation. Whether or not it really was a condition remains unclear, but in the client's eyes the entire process was intrusive and against her will. One day, Darnell found out that the teenage girl had fought back against her parents so strongly that her father physically restrained her while her mother drove the car to the office. Darnell immediately canceled the curriculum portion of the session, explained his intent that this be a safe space for her, allowed her to cool off, and eventually just had a conversation with her for the balance of the time.

Darnell, his supervisor, and the agency director then contacted the DOC administration, requesting a meeting with all of those in charge of the implementation, including the consultant. The DOC administration was sympathetic, while the consultant, obviously invested in the implementation efforts, said that Darnell should work harder to engage the young woman. Meanwhile, the agency did not want to harm their relationship with either the DOC or the consultant.

The agency team met and reviewed the basics. They had an ethical obligation to the client (the teenage girl) and only a contractual obligation to the DOC. The teenage girl was the person most affected by the appearance of being forced against her will into treatment. The team recognized that by continuing to provide treatment, neither of the "big four" ethical principles (autonomy, beneficence, nonmaleficence, and justice) was being served. They recognized that despite the best intentions of all, there were compromised boundaries and potential conflicts of interest across the board, with the result that the teenage girl felt neither protected nor connected. Further, if the structural boundaries were compromised (by the dual relationship of the DOC's providing both probation conditions and monitoring closely their contracted mental health treatment), the interpersonal boundaries were unacceptable, since the client trusted no one involved.

Compared to the harm of continuing with her in treatment, the harm to the agency of terminating the contract appeared quite small. Adopting the perspective of all involved, the agency team wrote a letter explaining the potential harms of continuing with treatment. They, after all, possessed the greatest expertise on trauma treatment in general and their clients specifically. They ensured that the DOC and consultant knew that it was their decision to terminate services and they bore complete responsibility. After exchanging viewpoints, the agency and DOC decided to terminate the contract altogether. Subsequent follow-up assessment by the agency's board of directors affirmed for them that this had been the right decision and neither the agency nor the DOC ever engaged in this type of collaboration again. What had started as a good idea ended up hopelessly conflicted and misapplied through practically no fault of any one individual.

What are the best ways to prevent boundary and ethical problems?

There are several models in psychotherapy that align themselves, directly or indirectly, with elements of effective, ethical practice as well as helping to ensure excellent professional boundaries. All professionals are encouraged to familiarize themselves with them, since they are evidence-based and practicing them can build one's interpersonal skills with clients and colleagues alike.

The first, *Motivational Interviewing,* is a person-centered counseling style that addresses the common problem of ambivalence about change (Miller & Rollnick, 2013; in press). It is centered on a foundational spirit of delivery that includes partnership, acceptance, compassion, and (in the most recent edition, in press at this writing) empowerment. Each of these spirit factors supports a professional approach that upholds beneficence, autonomy, justice, and nonmaleficence.

As examples, if a professional is conducting each issue in a spirit of partnership, in which they are essentially on an equal footing with the client, it can be easier to uphold these four ethical principles than if professionals view themselves as the experts in the room whose job it is to build a better life for their client (which is more in line with a physician-patient relationship). Partnership in this context involves the belief that while the professional may possess expertise in complex trauma, only the client is the expert on their own lives. Professionals who work in partnership with their clients are more like to be experienced as abstaining from any personal benefit in treatment or to be operating with a conflict of interest. These professionals are also more likely to provide a balanced sense of being both protected and connected to their clients. Perhaps most importantly, partnership lends itself to a sense of autonomy and adheres to nonmaleficence.

Likewise, the client who feels accepted by the professional is more likely to experience treatment as beneficent and supporting their autonomy in an environment of nonmaleficence. Accordingly, practicing with a priority on compassion and empowerment can uphold all four of the primary ethical principles. What is most fundamental in this way of working is its assurance of the client and professional as being equal, willing partners in change.

Another element of Motivational Interviewing is its emphasis on exploring and resolving ambivalence about change. Becoming expert on understanding how people with histories of complex trauma feel two or more ways about elements of their life can be extremely helpful to the client who feels stuck and unable to move forward with their life. Here are three examples, framed as double-sided reflective statements:

- "On one hand, you really want to feel better about your life, and on the other hand you are not sure where to start or if you have the energy to make changes."

- "On one hand, you want to focus on your future, and on the other hand it's like you're always needing to be on the lookout so that you don't get hurt in the here and now."

- "You're really feeling two ways about being in treatment. Part of you wants to get out of the hole you've been in, and part of you doesn't know if you can trust me or anyone else."

With each of these statements, it would be tempting to add that this experience is normal, to be expected, or otherwise completely understandable. In Motivational Interviewing, however, best practice is to ask permission of the client before sharing one's feedback or advice.

Ultimately, an aim of Motivational Interviewing is to allow each client to explore their own internal desires, abilities, reasons, and needs to make changes. By exploring and reflecting back these motivations, practitioners can help clients make the changes that are right for them, in an atmosphere that feels empowering, thus adhering to the ethical principles of effective practice, as well as upholding boundaries that contribute to client safety.

Another approach that can uphold ethical principles and maintains boundaries is *Feedback-Informed Treatment* (FIT; Prescott, Maeschalck, & Miller, 2017; 2023). FIT is a transtheoretical approach that uses ongoing administration of outcome and alliance measures to collect real-time client feedback about their experience in therapy. "Transtheoretical" means that FIT can be applied across disciplines, no matter what treatment approach the therapist is using. Although FIT can improve the effectiveness of professionals over time, it is mentioned here because of its established capacity to improve client outcomes.

Central to FIT is its focus on collecting feedback from the client on measures of wellbeing and the therapeutic/working alliance. Of particular interest in working with complex trauma, FIT ensures that the client has a voice in treatment at every step. Within this method, it is vital that professionals:

- Create a culture of feedback in which clients are free and encouraged to rate and discuss their experiences without fear of retribution or complication, and with the hope of having an active role in the course of their own treatment.
- Demonstrate that they have strongly considered that feedback and have taken action accordingly. This can take different forms. One client once noted that the therapist's office needed more artwork on the walls and was delighted to return the following week and found that his therapist had agreed and hung up more paintings. Another client once told the author to ask more pointed questions and to challenge him more, and he became more involved when this happened in subsequent sessions.

Getting heartfelt, honest, and actionable feedback from clients requires considerable skill. For professionals who are more accustomed to an expert-driven approach (in which the professional is the expert whose approach is better left unchallenged), it can require rejecting erstwhile approaches, attitudes, and beliefs about clients and treatment processes. Nonetheless, by viewing the client's input into treatment services as meaningful and requiring consideration, professionals are more likely to practice with nonmaleficence, justice, autonomy, and beneficence.

For clients with histories of complex trauma, inviting feedback on the alliance can reverse age-old patterns of deferring to others who have more power; this is one reason why it can be so difficult to elicit the client's voice. In essence, the professional is asking:

- "In our work together, how well am I hearing, understanding, and respecting you?"

- “How much are we talking about the goals and topics that are personally relevant and important to you, or that you want to talk about”
- “How effective is my approach with you?
- “Overall, how is our work together?”

One professional who participated in a study and was found to be among the most effective therapists studied once remarked privately, “What I’ve learned is that I need feedback not because I’m a great therapist; I’m not. Rather, if I don’t get feedback, all of my assumptions and approaches will be wrong more often than they’re right.”

Going upstream

As a brief though exercise for upholding excellent boundaries and ethics, consider:

What is one thing that any client with complex trauma might want right now? It can be as simple as to enjoy a trip to the supermarket. Then ask, if they had that in their lives right now, then what would they have. For example, the client who wants to enjoy a trip to the supermarket may feel that they are able to do something effectively. If they could do something effectively, then what else would they have in their life? It may be that this sense of effectiveness means that they can make decisions for themselves based on what they want and not on what others want from them. And upstream from making their own decisions is independence and autonomy.

By continually exploring what is upstream from a particular issue or behavior, practitioners can better align with what is personally meaningful and relevant to the client. Through this alignment, we can become better attuned and display more effective empathy and compassion. By doing each of these, the professional can better uphold beneficence, autonomy, justice, and nonmaleficence. This can be particularly useful in the midst of managing certain tasks of treatment, such as ensuring that clients take their medications, sign treatment plans, etc. It can be useful to remember that upstream from every situation are broader goals that the professional can connect with. The client’s search for autonomy, independence, and justice in their lives may be just beyond otherwise challenging behaviors such as opposition, defiance, or refusing to participate. By respecting the larger goals, professionals are in a better position to help their clients.

A meditation on boundaries[3]

Complex trauma typically stems from abuse and broken boundaries. This means professionals need to guard against leaving clients feeling unprotected or unconnected or creating boundaries that are blurred or diffuse. Among the best ways to prevent blurred, diffuse boundaries is to contemplate how they work in one’s life. To that end, professionals and clients alike may benefit from a contemplative exercise to explore the nature of one’s boundaries:

Take a moment to relax where you are. You may be standing, sitting, or even lying down. If you like, you can feel your body connecting with both the ground below and the atmosphere above

[3] I am grateful to author Langston Kahn (2021) for his work in this area, on which this exercise is based.

you. If you like, you can relax your shoulders and slow your breathing. You can relax the muscles in your face and let go of any tension in your hips or legs. You can also let go of any thoughts that might have been troubling you or put them to one side as you go through this activity.

As you relax and feel yourself becoming centered you can start to sense where your boundaries are. Boundaries can change shape and size or vary from what you say to others to how you allow others' actions to affect you. Some people feel more like they are surrounded by little walls when they are on a city busy while others feel as though they have more expansive boundaries when out in nature. Where are yours right now?

There are those who experience their boundaries as a sort of egg shape around their body, while others feel boundaries as a kind of energy shield roughly the same shape of their bodies. Everyone is different. Where do you feel yours?

As you explore your boundaries, you might look at them from the outside. What color (or colors) are your boundaries? How do the colors change in different circumstances? What do your boundaries look like and feel like from the outside?

Next, you might imagine touching the inside of your boundaries with your fingers. What do your boundaries feel like? What do they look like on the inside? Do things sound different on the inside of your boundaries or the outside? Some people have even been curious to see if they can smell or taste their boundaries, but this is all up to you.

As you explore your own boundaries in this way, are there any places where they've been damaged or need repair? If so, how can you best attend to these places? Is there someone or something that can help you? Have there been events in your life that caused you not to attend to these boundaries? As you work on bringing them back to full strength, how might you continue to maintain them? How often would you like to check in on your boundaries to make sure that you are protected, connected, and can best be of service to yourself and others?

As you reflect on your own boundaries, you can also consider what you may need in order to look after them in your daily life in the most effective ways, and plan accordingly.

Conclusion

Thinking of boundaries and ethics as ongoing processes involving different steps, approaches, and skills can protect both the client and the professional. The most ethical practices support client autonomy, provide beneficence and justice, and uphold nonmaleficence. Clients who feel protected and connected will always be more positively affected by interventions. The most skilled professionals, and the safest agencies, work to uphold these principles every day.

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