The Conversation Continues...
Historical Shifts in the Debate on Therapeutic Boundaries

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What the Debate Is About

Why do we need to debate issues of therapeutic boundaries? Aren't they clear? In fact it is very simple as long as we do no harm, treat our clients with respect, do not have sex with them, protect their privacy and employ our skills in the best we can to alleviate their suffering. Then, is it that simple? While almost all therapists agree on the above principles, the question remains as to whether or not our ethical principles give us sufficient guidelines to navigate through the deeply complex issues of touch, self-disclosure, gifts, bartering, home visits and the most debated of all, dual relationships.

Three Sets of Debatable Questions

Consider this first set of dilemmas:

- Your client of five years would like to stop therapy and pursue a sexual relationship with you.
- Johnny, with your help, has finally overcome his school phobia. His rather affluent parents, in appreciation for your help, have sent you an expensive season ticket for a luxury box for your beloved baseball team's upcoming season.
- Your client is about to move to another state, where you are not licensed, and would like to continue therapy with you.

The answers to the above questions seem to be clear. Terminating treatment to pursue a sexual relationship is unethical and illegal; accepting an expensive gift, regardless of how wealthy the parents are, is counter clinically and ethically questionable; and practicing telehealth across state lines in a state where you are not licensed is also unethical and illegal.

Now, consider the next set of dilemmas:

- Your client, who was involved in a car accident and is who bed-ridden, home bound and depressed, asks you to make a home visit to help with the depression and to continue treatment.
- A potential client asks you on the phone, during a phone interview, whether you believe in God.

- You discover that one of your clients has signed up for the same basketball league you have signed up for.

These questions are more complex than the first set of question and are likely to draw different responses from different therapists. Ethical decision-making by a cognitive-behavioral therapist is likely to yield a different conclusion to the home visit dilemma than a transference-focused traditional psychoanalyst. Humanistic or feminist psychotherapists and those who are trained cross-culturally generally see the clinical value of self-disclosure and are likely to respond more frankly to the question of their belief in God than traditional psychodynamically oriented therapists who see the importance of neutrality. Risk-benefit analysis by a rural therapist is likely to lead to a different outcome than their urban counterpart in the basketball situation as they are used for many types of unavoidable dual relationships.

Finally, consider this set of questions:

- A sobbing, grieving mother-client, who just lost her young daughter in a car accident, asks you to hold her.
- A couple whom you have helped a lot in their pre-marital struggles would not consider getting married without you, their highly appreciated therapist, being present.
- A Latino/a client gives you a handmade gift for the holidays.

Whether a therapist decides to hold the mother, attend the wedding, or accept the gift is primarily determined by the setting of the therapy, the therapist's orientation, and most importantly the significance that risk management and fear plays in the therapist's (clinical) mind.

Historical Shifts in the Debate on Therapeutic Boundaries

The fields of psychotherapy and counselling have seen numerous shifts in attitudes towards boundaries in psychotherapy. Conflicts, debates and disagreements have abounded since the inception of the discipline. Paradoxically, Freud, who laid the foundations for strict, analytically based, therapeutic boundaries, crossed many of them himself. He gave some of his patients gifts, provided financial support to others, entered into a matchmaking arrangement with two of his clients, and offered a meal to the patient known as the Rat Man. Melanie Klein and Freud both analyzed their clients during their vacations and crossed the professional-familial line by analyzing their own children. Winnicott, like Ferenczi, touched his clients, and Carl Jung slept with them (Gutheil & Gabbard, 1993). However, in the early 1930's this attitude shifted and Freud became concerned with the reputation and image of the budding new discipline of psychoanalysis. Ferenczi and Reich, two prominent psychiatrists and members of Freud's inner circle were expelled from the International Psychoanalytic Association; the former for kissing his clients and the latter for employing comprehensive methods of clinical touch (Zur, 2007).

The concerns with therapeutic boundaries came to the forefront of the field after Gestalt therapy, with Frederick Peris at the helm, which became enormously popular during the sexual revolution of the 1960s. Manifest sexual and other boundary violations were openly espoused at Esalen Institute in California, where therapists and clients often became playmates and . . . lovers. In response to the sexually and other permissive attitudes of the 1960s and 1970s, there was pressure on psychology to articulate and provide more specific guidelines regarding therapists' conduct vis-a-vis their clients. As a result, consumer protection agencies, licensing boards, and legislators joined ethicists and psychotherapists in establishing clear restrictions with regard to therapist-client sexual dual relationships (Gutheil & Gabbard, 1993). Therapists were instructed not only to resolutely avoid sexual relationships but also to make every effort to avoid any kind of boundary crossing dual relationship.

The increasingly litigious culture of the 1980s and thereafter, as well as the increased focus on risk management in medicine, continued this shift and led to more spoken and unspoken injunctions against any deviation from hands-off, only-in-the-office, "no self-disclosure" therapy. Barter, gifts, nonsexual touch, and dual relationships were generally viewed as hazards from a risk management standpoint and the first step in the slippery slope towards sexual relationships and potential harm (Pope &Vasquez, 1988).

The early 1990s witnessed a growing acknowledgment that boundary crossing, such as nonsexual touch and self-disclosure, can be clinically helpful. There was also increased recognition that non-sexual dual relationships were unavoidable under some circumstances, such as in rural areas, small towns, military settings, and among constituents of distinct individual communities, such as churches, the deaf community, the LGBT community, and other minority cultural groups (Zur, 2007). Partly in response to this growing awareness, the APA (1992) and other professional associations revised their codes of ethics, particularly with regard to dual relationships.

From the mid-1990s to the present time, the debate on the utility and ethics of therapeutic boundaries has intensified. On one side of the debate, consumer protection agencies, licensing boards, risk management experts, many ethicists, and psychoanalytically oriented therapists continue to advocate clearly defined and distinct boundaries around the therapeutic relationship and between therapists and clients. On the other side of the debate, there have been a growing number of ethicists and professionals who point out that flexible boundaries can be clinically helpful when applied ethically (e.g., Knapp *&C* VandeCreek, 2006; Lazarus & Zur, 2002). Additionally, there have been a growing number of publications that discuss the fact that nonsexual dual relationships are neither always avoidable nor always unethical or harmful and, in fact, can be clinically beneficial (Younggren *&C* Gottlieb, 2004; Zur, 2007).

A few years into the 21st century we have seen a more profound change. Professional associations, such as APA (2002), ACA (2005) and USABP (2007) have significantly revised their codes of ethics, presenting non-rigid, flexible and context-based approaches towards boundaries. Of significance is the apparent shift among some of the most staunch supporters of the rigid application of therapeutic boundaries and "the slippery slope" argument, who have altered their positions and have been publishing (e.g., Pope &C Wedding, 2007; Sonne, 2006; Vasquez, 2007) a welcomed, more balanced and flexible view of therapeutic boundaries, albeit with minimal explanation regarding the nature or reason for the change.

And So, the Conversation Continues

The debate on the meaning and management of therapeutic boundaries is alive and well. Clinicians are not always inclined to "agree to disagree," but the question arises: are we prepared to move beyond labeling each other as "unethical" so that we can continue a productive debate on therapeutic boundaries? As the number of professionals who advocate flexible and realistic applications of therapeutic boundaries is growing, we must also ask whether or not licensing boards, ethics committees, graduate school instructors and the courts will keep pace with the changes. It's imperative that we stay engaged in the discussion. It's important for psychology and for our clients.

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