

# THERAPEUTIC BOUNDARIES AND DUAL RELATIONSHIPS IN PSYCHOTHERAPY AND COUNSELING

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## *I - Boundary Crossings and Boundary Violations In Therapy*

- ◆ **Boundaries** in psychotherapy refer to issues of self-disclosure, length and place of sessions, physical touch, gifts, bartering, activities outside the office (home or hospital visits, attending clients' weddings or school plays, lunch with an anorexic client, adventure therapy, etc.), incidental encounters, social and other non-therapeutic contacts, online social networking contacts, and various forms of dual relationships.
- ◆ In recent years the topic of boundaries has been extended to include "**digital boundaries**" such as e-mail and text contacts, telehealth, Google, and issues regarding online social networking between therapists and clients.
- ◆ **Boundary crossings and boundary violations** generally refer to any deviation from traditional, strict, 'only in the office,' emotionally distant forms of therapy. Basically, they may all be seen as a departure from the traditional psychoanalytic or rigid risk management approaches.
- ◆ **Boundary violations in therapy are different from boundary crossings.** While boundary violations by therapists are harmful to their patients, boundary crossings can be clinically very helpful.
- ◆ **Harmful boundary violations** occur typically when therapists are engaged in exploitative dual relationships, such as sexual contacts with clients or exploitative business relationships.
- ◆ **Boundary crossings** can be an integral part of well-formulated treatment plans or evidence-based treatment plans. Examples are, giving a supportive hug to a grieving client, accepting a small termination gift from a client, flying in an airplane with a patient who suffers from a fear of flying, bartering with a cash-poor farmer, lending a CD to a client, making a home visit to a bed ridden patient, attending a wedding, going to see a shy client performing in a show, or accompanying a patient to a dreaded but important doctor's appointment.
- ◆ **Ethics codes** of all major psychotherapy professional associations (e.g., APA, NASW, ACA, NBCC) do NOT prohibit boundary crossings, only boundary violations. Most of these codes state that multiple relationships should be avoided if they could reasonably be expected to impair the therapists' effectiveness or cause harm.
- ◆ **Therapeutic orientations**, such as humanistic, behavioral, cognitive, family systems, feminist or group therapy, often endorse boundary crossings as part of effective treatment.
- ◆ What constitutes harmful boundary violations according to one theoretical orientation may be considered helpful boundary crossings according to another.
- ◆ As with dual relationships, **boundary crossings are unavoidable and expected** in small communities, such as rural, military, universities and interdependent communities, e.g., church, deaf, ethnic, LGBT, etc.
- ◆ **Different cultures** have different expectations, customs and values regarding therapeutic boundaries.
- ◆ **Not all boundary crossings constitute dual relationships.** Making a home visit, going on a hike, or attending a wedding with a client are boundary crossings, but do not necessarily constitute dual relationships.
- ◆ There is a prevalent, erroneous and **unfounded belief about the 'slippery slope'** that claims that minor boundary crossings inevitably lead to boundary violations and sexual relationships. This illogical, unscientific and paranoid approach is based on the 'snow ball' effect. It asserts that the giving of a simple gift likely ends up in a business relationship and a non-sexual hug inevitably turns into a sexual relationship.
- ◆ A rigid attitude towards boundary crossings stems in part from '**sexualizing boundaries.**' This is a distorted view, more prevalent in the US, which views all boundary crossings as sexual in nature.
- ◆ Boundary crossings with certain clients, such as BDP, must be handled with caution.
- ◆ Boundary crossings and multiple relationships should be implemented **according to the client's unique needs**, Dx, history, etc., and the context of therapy. It is recommended that the rationale for boundary crossings be articulated in the records and, if appropriate, included in the treatment plan.
- ◆ The appropriate **meaning and applicability of boundaries** can only be understood within the **context** in which therapy takes place. The context of therapy consists of client, setting, therapy and therapist factors.
- ◆ **Attitudes towards therapeutic boundaries** have been significantly changing since the 1990s. While we still have a long way to go, there is better understanding of the nature of boundaries and the importance of flexibility.

## II - Dual Relationships in Psychotherapy

**DEFINITION:** Dual relationships, or multiple relationships, in psychotherapy refer to any situation where multiple roles exist between a therapist and a client. Examples are when the client is *also* a student, friend, family member, employee or business associate of the therapist.

- ◆ **Non-sexual dual relationships are not necessarily unethical or illegal.** Only sexual, exploitative and harmful dual relationships are unethical and can be illegal. Most of the major professional associations' codes of ethics state that multiple relationships should be avoided if they could reasonably be expected to impair the therapist's effectiveness or cause harm.
- ◆ **There are several kinds of dual relationships:**
  - Dual relationships can be **avoidable, unavoidable** or **mandated**.
  - They can be **consecutive** or **sequential**.
  - They can be **expected** or **unexpected-accidental**.
  - They can be **initiated** by therapists, clients, both or a third party.
  - They can be of **low, medium or high intensity**.
- ◆ **Dual relationships are often unavoidable** in rural and small communities, the military, forensic settings, church and LGBT communities and among people with HIV/Aids, Hispanics and many other minorities.
- ◆ **Non-sexual dual relationships do not necessarily lead to exploitation, sex or harm.** The opposite is often true. Appropriate/healthy dual relationships can prevent exploitation and sex rather than lead to it.
- ◆ **Almost all ethical guidelines do not mandate a blanket avoidance of dual relationships.** All guidelines do prohibit sexual dual relationships with current or recently terminated clients and exploitation of clients.
- ◆ **Exploitative therapists will take advantage, with or without restrictions,** of dual relationships. In fact, avoiding all dual relationships keeps therapists in unrealistic and inappropriate power positions, increases the isolation and can also increase the likelihood of exploitation.
- ◆ **There are several types of dual relationships:**
  - A **social dual relationship** is where therapist and client are also friends (online or offline).
  - A **sexual dual relationship** is where therapist and client are also involved in a sexual relationship. Sexual dual relationships with current or recently terminated clients are always unethical and often illegal.
  - A **professional dual relationship** is where therapist and client are also professional colleagues, as often is the case in colleges and training institutions or co-presenters in professional conferences.
  - A **business dual relationship** is where therapist and client are also business partners or have employer-employee relationships.
  - A **communal dual relationship** is where therapist and client live in the same small community, belong to the same church or synagogue or have children in the same school.
  - Institutional dual relationships** take place in the military and prisons, in police department settings and in mental hospitals where dual relationships are an inherent or mandatory part of the institutional settings.
  - Forensic dual relationships** take place when a therapist serves as an expert as well as a clinician.
- ◆ **Dual relationships can be avoidable, unavoidable or mandated:**
  - Voluntary-Avoidable:** Usually these dual relationships take place in large cities or metropolitan areas where there are many therapists, many places to worship or recreate.
  - Unavoidable:** These dual relationships are often found in rural areas, small minority groups, disabled groups, spiritual communities, training institutions or any small community in a big metropolitan area.
  - Mandated:** These dual relationships take place in the military, prisons and in some police department settings.
- ◆ **Dual relationships can be concurrent or sequential:**
  - A **concurrent dual relationship** takes place at the same time as therapy.
  - A **sequential dual relationship** takes place after therapy has ended. For example, after therapy ends a therapist and client decide to embark on social or business relationships.
- ◆ **There are several levels of involvement in dual relationships: Low level of involvement:** When a therapist runs into a client in the local market. **Medium level:** When a client and therapist share occasional encounters, as in attending church services every Sunday. **Intense:** When a client and therapist are very involved and share an ongoing social, professional or business relationship.
- ◆ The prohibition of dual relationships leads to increased **isolation**, which has several serious ramifications:
  - Isolation inflates and increases the perceived power of the therapist.*
  - Isolation can increase the chance of exploitation of clients by therapists (e.g., basic training, cults).*
  - Isolation in therapy can reduce effectiveness as clients' difficulties are often caused by isolation.*
  - Isolation forces the therapist to rely on the client's reports. Therapeutic effectiveness can be diminished by lack of collateral information and exclusive reliance on a client's subjective or distorted accounts.*
- ◆ Not all **therapeutic approaches** disparage dual relationships. Behavioral, humanistic, cognitive, family, group and existential therapy at times see dual relationships as an integral part of the treatment plan.
- ◆ Some **graduate and postgraduate education** not only instill a fear of licensing agencies and lawsuits but also deliver inadequate instruction in critical thinking, personal integrity and ethics.
- ◆ Out-of-office experiences that are part of the treatment plan, such as attending a child's school play or in-vivo exposure outside the office, do not create dual relationships.

### III – Clinical-Ethical Recommendations

- ◆ The appropriate meaning and applicability of boundaries can only be understood within the **context** in which therapy takes place. The context of therapy consists of the following five components:
  - Client factors: Culture, age, gender, acculturation, language, history of trauma, sexual/physical abuse, presenting problem, severity of mental disturbances, class, personality, social support, etc.*
  - Setting factors: Outpatient vs. inpatient vs. day program; solo practice vs. group practice; office location (e.g., home office, hospital); locality (rural, urban, reservation, university, military base, prison); elective vs. mandated; voluntary hospitalization vs. involuntary; In person (f2f) vs. Telehealth, etc.*
  - Therapy factors: Individual vs. family vs. group therapy; short term vs. long term; frequency; child vs. adult psychotherapy; psychoanalysis vs. humanistic vs. group therapy vs. body psychotherapy; etc.*
  - Therapeutic relationship factors: Quality/nature of therapeutic alliance; length, phase in therapy; idealized/transference relationships vs. egalitarian relationships; familiarity and interactivity in community vs. only in office; presence or absence of dual relationships; etc.*
  - Therapist factors: Culture, age, gender, sexual orientation, experience, training, etc.*
- ◆ Develop a clear **treatment plan**, which is based on client's problems, needs, personality, situation, venue, environment and culture. Intervene with your clients according to their needs and personalized treatment plans and not according to any supervisor's dogma or even your own beloved theoretical orientation.
- ◆ Some treatment plans may necessitate boundary crossing or dual relationships; however, in other situations they should be ruled out. Make sure you know the difference.
- ◆ Conduct a **risk-benefit analysis** before crossing boundaries. Remember that inaction, such as rigid avoidance of all boundary crossing or rigid avoiding entering into any dual relationships, may be harmful.
- ◆ In planning to cross a boundary or enter into a dual relationship consider the welfare of the client, effectiveness of treatment, avoidance of harm/exploitation, conflict of interest and the clinical impairment.
- ◆ **Do not let fear of lawsuits, licensing boards or attorneys** determine your treatment plans or clinical interventions. Act with competence and integrity while minimizing risk by following these guidelines.
- ◆ **Do not enter into sexual relations** with a current or recently terminated client.
- ◆ Remember that **treatment planning** is an essential part of your clinical records and your first line of defense in case of an administrative or criminal investigation.
- ◆ Consider the **clinical, ethical and legal** complexities and potential ramifications before crossing boundaries or entering into dual relationships.
- ◆ **Consult** with well-informed, open-minded and non-dogmatic consultants, clinical, ethical or legal experts in complex cases before crossing intricate boundaries or entering into complex dual relationships. Document the consultations well.
- ◆ Attend to and **be aware of your own needs** through personal therapy, consultations, conversations with friends, supervision or self-analysis.
- ◆ **Remember you are paid to do a job, not to protect yourself or practice strict risk management.**
- ◆ **Discuss** with your clients the complexity, richness, potential benefits, drawbacks and likely risks that may arise due to dual relationships. When appropriate, share with them your risk-benefit analysis.
- ◆ Make sure that, when appropriate, your **office policies** include the risks and benefits of boundary crossings and dual relationships and are explained, read and signed by your clients prior to their implementation.
- ◆ Make sure your clinical records document includes consultations, substantiation of your conclusions, potential risks and benefits of specific interventions and the discussion of these issues with your client.
- ◆ At the heart of all **ethical guidelines** is the mandate that you act on your client's behalf and avoid harm. That means you must do what is helpful, including, when appropriate, crossing boundaries and engaging in DR.
- ◆ **Power relationships in therapy** are complex. Unlike the myths of "inherent power differential," "imbalance of power" or "clients' inherent vulnerability," power relationships in therapy are *not* that simple and clear. While therapists may have some types of power, clients have different forms of power.
- ◆ **Digital boundaries** are complex and evolving, they involved Facebook Friends with clients, therapists Googling clients, texting with clients, therapists' online transparency and much more.
- ◆ Regularly evaluate and update your approach, attitudes, **treatment plans** and, above all, effectiveness.
- ◆ **Model civility, integrity, emotionality, humanity, courage and, when appropriate, duality.**

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