Boundaries in Psychotherapy and Counseling
An overview of professional boundaries and how they have changed over time

With Ofer Zur, Ph.D.

Ofer Zur: Hello, this is Doctor Ofer Zur. I'm the director of the Zur institute. This presentation is about boundaries and dual relationships in psychotherapy and counselling. We are going to explore the complexities of boundaries in therapy and dispell the myths around boundaries, with the hopes that all this will increase therapeutic effectiveness.

Therapeutic boundaries include the following: gifts, touch (physical touch), self-disclosure (or what have been called transparencies), bartering, home office (what I've called out-of-office experiences which include home visits or walk on a trail with a client), dual relationships, and then the issues of time, proximity, and space as well as issues of clothing, language, and fees.

Therapeutic boundaries define the therapeutic fiduciary relationship between therapist and client. The outline, what has been called the therapeutic frame, distinguishes between psychotherapy and non-clinical modes, such as friendship, social relationship, familiar relationship, sexual relationship, business realtionship, or many other non-clinical relationship.

It has been hard to define boundaries in therapy. Generally, they refer to any deviation from traditional, strict, or only in the office form of therapy - deviation from emotionally neutral or distant form of therapy, or they refer to some rigid application of risk-management protocols.

There are two types of therapeutic boundaries. There are boundary violations and there are boundary crossings. Boundary violations are easier to define as they occur when therapists cross a line of decency, violate or exploit their clients, or intentionally harm them. Boundary crossings are a little bit more complex, because they involve neutral, appropriate, ethical, benign, and clinically effective interventions. Examples of boundary crossing are clinically appropriate self-disclosure, home visit with a bedridden patient, hospital visits to a patient, non-sexual appropriate touch, appropriate ritualistic or small gift giving, ethical and appropriate bartering. Attending a wedding is a boundary crossing. Attending a graduation, attending church with a client, and other dual relationships in a community are all boundary crossings.

Generally, there are other ways to look at boundaries. There are boundaries around a therapeutic relationship and there are boundaries between therapist and client. Boundary crossings that are around the therapeutic relationship involve the time of the sessions, the place of the sessions, whether they are sessions in- or out-of-office, such

as in home visits or home office. Fees, bartering, confidentiality, and privacy are all boundaries that are around the therapeutic relationship.

In contrast, boundaries that are between therapist and client involve therapist's self-disclosure, any forms of touch between therapist and client, gift exchange, dual relationship, and there are issues of language, dress, attire, proximity, and distance (how far or close the therapist sits in relationship to the client).

The most important aspect of therapeutic boundaries is that it can be only understood within the context of therapy that had been employed. So, what's right or what's appropriate in one context is not appropriate or ethical, or sometimes legal in a different context. We will talk more about the context of therapy towards the end of this presentation.

The context of therapy includes several factors: client factors, setting factors, therapeutic orientation factors, relationship factors, and therapist factors.

Let's review different types of boundary crossings. We will start with self-disclosure. The definition of self-disclosure is "the revelation of personal rather than professional information" about the therapist to the client. There are many types of self-disclosure. Some of them can be deliberate. Deliberate self-disclosure can be verbal or can be non-verbal. There can be a gesture or just a facial expression. Self-disclosure can be avoidable or unavoidable; for example, my accent is unavoidable self-disclosure, pregnancy is unavoidable self-disclosure, sometimes clients talking to each other about the therapist online/offline, this is also unavoidable self-disclosure. Accidental self-disclosure in the community; it happens often in small community, in the LGBT community, in big cities, in church communities, on college campuses, etc., and it can be a result of clients' action, when clients talk to the therapist, or in a modern version of stalking, googling, or cyber stalking the therapist. There are certain populations where self-disclosure has been reported to be really important for clinical outcome. That includes LGBT, veterans, alcohol and drug use, parenting, and when the clients are abused women.

Let's talk about the modern era phenomenon of what I've called the Google Factor. There are many ways that clients can find information about the therapist. I'm going to differentiate between five levels of ways for clients to Google us therapists. The first level is what I call 'Google Light'. It is a simple curiosity when the client puts our first and last name into Google search and finds out whatever comes up on the search. The second level is a little bit more, when a client is due diligent. It's a much more thorough research. They may look into Google Scholar and may look within other pages, and put different combination of our names, like my name, it would be Ofer Zur, or it would be Dr. Zur, or it would be Dr. Zur Ph.D., etc. The third level is when the clients cross the line and use a pseudonym and they try to join us on Facebook, etc. and we are communicating with them without knowing really who they are. The fourth level is when they use intrusive search and they're going to list us and, again, maybe using a pseudonym. At times of this kind of situation, clients can actually hear or read when the

therapists discuss their own cases online with fellow other therapists. The fifth level is illegal search, when the client can pay online agencies $20-40 and will actually get therapist's phone records and that. This level is what I've called cyber-stalking.

What can therapist do about these issues about online disclosure by therapist? The first, and most important, thing the therapist can do is to expect prudent and informed consumers to Google you. Our modern clients do not see themselves as clients, they don't see themselves as patients. They see themselves as consumers entitled to be informed; nothing is in fact wrong about it. Before I have surgery, I would like to know whether too many patients died on the surgeon's table before me, I would like to know - did this surgeon lose his or her license, etc. Prudent modern age consumers Google their providers.

The second thing I would like to advise therapists about is to be careful about any web postings, whether it's Facebook, Twitter, or any kind of blogs that you enter. Consider any entry of your personal information online as, what Dr. Rosen said, as if it's tattooed on your forehead. It's going to be there forever, even though the webpage may have not still be online, there's enough search engines that can detect and bring up old webpages.

I suggest that you Google yourself regularly. It's very simple. Sign up for Google Alert and go to google.com, and find alerts. Just put in your name; it's free, and you can get all the records of anybody who mentions you. I suggest when you do the Google Alert, you put it in different combinations. Again, if I use my name as an example, you can put Dr. Ofer Zur in parentheses, you can put Ofer Zur in parentheses, Zur Ph.D., Dr. Zur, so, it's like four, five, six combinations. Put them into Google Alert and see whenever there is an entry about you online. You will be notified every day or as it happens, or once a week, depending on the way you sign up for notifications.

When you find out about negative evaluative postings about you online, be very careful. Don't respond impulsively. Don't protest too much, because sometimes protesting too much creates] much more negative publicity. Before you file a law suit, consult with several informed experts and attorneys, because sometimes you can win the battle and lose the war just for the negative commotion that you get.

Ultimately, when it comes to clients Googling us, or when it comes to information online about us therapists, we need to surrender. Clients can find our home addresses; they can find out who's in our family; they can find out not only where we live but sometimes how we live, our neighbors, our income, our divorce papers; all this is often available free and very available online.

The second boundary I would like to discuss is a home office. The home office involves usually a way of self-disclosure. Usually self-disclosure in a home office setting is how clients get to know a lot about our families, children, housemates. They often can get some sense about the economic status and income level of the therapist according to the neighborhood where the house is located. Sometimes they can find out about the

therapist hobbies, whether they see cars in the garage or beautiful gardens up front. It also depends if the home office is part of the house. Is it a designated room in the house, is it the living room, or is it a detached unit? So, it depends. Home office can have different levels of self-disclosure, but there's always some level of self-disclosure. Clients can get the sense of our taste in art and design, and furniture. They can get it in our regular offices but also, much more so, in the home office. Sometimes they can get a sense of cooking smells and sounds coming from the house, which tells them personal information about us.

Home office also involves a whole range of potential unexpected occurrences. Therapists sometimes discuss the children when we're wandering into the office. Sometimes dogs are barking. Sometimes therapist's neighbors or friends were visiting not knowing that the therapist is conducting a home office session. The whole range of unpredictability that comes with a home office does not necessarily mean it's not a good idea to have home office; but one has to take these factors into clinical and ethical consideration while working from home.

The next type of boundaries I would like to discuss is probably a type of boundaries that all therapists have encountered in their career, whether they are young or have been in the field for 20-30 years. This is the issue of gifts. There are generally three types of gifts. There are gifts from therapist to client, there are gifts from client to therapist, and there are gifts that come from a third party to the therapist. The third party gifts involve parents or spouse of clients. If you see children in therapy, the parents may give you a gift. The psychopharmaceutical companies always give samples and medication. They give pens, and they give calendars, and all kind of gadgets that some may consider a gift or others may consider bribes. Other professional businesses may give you gifts.

Gifts and therapy can be appropriate, like a small CD or small graduation presents, where others can be inappropriate. I can think, depending on the context of therapy, condoms would be an inappropriate gift from therapist to client unless the therapist works with a special population such as HIV/AIDS, where giving condoms may be appropriate. Again, it all depends on the context. Gifts can be inexpensive. They can involve just a little symbolic gift like a CD or a DVD, or can be very expensive, like somebody talked about a client giving them a car. Most of the gifts that we see from therapist to client are customary, ritualistic, or celebratory small gifts that the therapist gives to clients. Gifts from client to therapist range widely between appropriate and inappropriate, from very cheap and very simple to highly expensive, which is usually inappropriate.

Some of the gifts that I have given during my career to my clients were, when I go to Israel, I bring a rock from Jerusalem. Some clients find it very meaningful. It helps them sometimes to contain anxiety or it acts as a transitional object. Sometimes I brought water from the John River. I have definitely given a lot of graduation gifts to clients; graduation from high school, graduation from a college etc. to celebrate an achievement. I've received a lot of food as gifts around the holidays; I've received CDs and DVDs; I have received flowers bouquets. Sometimes I received inappropriate gifts

that had a sexual connotation, and that's something that I didn't accept and just talked to the client about the meaning of a gift.

There's a myth that you need to talk to every client about the meaning of the gift. That's not always correct. Sometimes you just say 'thank you' and sometimes you discuss the meaning of the gift. If it's a client that got into the habit of buying love by giving gifts, of course, it's a clinical issue. If it's a super expensive car, regardless how much money the clients have, it's always a clinical and ethical issue. When a rich client gives very expensive gifts to the therapist, the therapist must be very cautious, whether it's a car or a vacation home, or season tickets. Therapists must be very cautious because rich clients know the value of money. Often rich clients are used to people who want their money, and often they buy love with money, or buy relationships with money. So, the fact that a client is very rich, by itself, does not necessarily mean that it's okay to accept a very expensive gift. What we often need to do in this situation is to think about the clinical, ethical, and legal complexities. I highly advise that you get a consultation before you cross a boundary that is not really simple, but rather complex, and can be very clinically confounding.

The next boundary I would like to discuss is probably the most controversial one. This is a boundary of touch in therapy, physical touch in therapy. Like any other boundary crossing discussed today, it can be appropriate or inappropriate. It can be part of verbal psychotherapy, for example when you shake hand or give a hug or touch a shoulder of a client in distress. It can be part of body psychotherapy. Aggressive touch, which is violent, is, of course, unethical and inappropriate. However, aggressive restraining touch may be appropriate, when a client is self-harming.

There are many, many types of touch in therapy. My article 'To touch or Not to Touch' outlines I think 18 or 20 forms of touch. They include ritualistic touch, task-oriented touch, inadvertent touch, controversial marker, consolation, reassuring, playful, grounding, coercive experience, instructional, celebratory, and many more. Of course, sexual touch is inappropriate and so is hostile or violent touch.

The next type of boundaries I would like to discuss, another controversial type, is bartering; bartering for goods and bartering for service. Bartering for goods is when you exchange a painting or a car or a sculpture for therapy. Bartering for service is when you exchange services of a client, such as house cleaning or car repair. Bartering for goods is easier to navigate. Bartering for services can be a complex dual relationship. It's easier to have the fair market value for bartering for goods. For services, it's complex. Do you exchange a dollar for a dollar? It can be much more complicated.

The additional type of boundaries combine goods and services, where sometimes you barter for a client giving service not to the therapist but to some charity. Interesting to barter with the wealthy when they give money perhaps to some kind of charity, but you give them therapy instead. Some psychological associations in California in the 90s attempted to do bartering, swapping guns for therapy in an attempt to get guns off the street.

Ways to arrange bartering are varied. You do direct, you do personal communication between the therapist and the client. Sometimes there are trade associations that you don't negotiate directly with the client, but you have a third party that arranges the bartering.

Now we are in the era in which we have a lot of online bartering and in the future, my sense is there will be a lot of e-therapy being done through bartering online. One of the questions that I have about bartering is why bartering has become so ethically questionable that associations like CAMFT, the California Association of Marriage and Family, and other associations have actually declared bartering, in so many words, as unethical. Why has bartering been criminalized while it is really a part of human experience?

The next type of boundaries I would like to discuss is what I call out-of-office experiences. Out-of-office experiences include home visits, attending a wedding, confirmation, Bar Mitzvah, or school play of our clients. It also includes adventure or nature therapy, when you do an anorexic lunch, when you do desensitization or exposure therapy, and when you join clients on a dreaded but very important medical appointment.

Out-of-office experiences can be part of a treatment plan, like flying with the person with a fear of flying or going to an open space with an Agoraphobic. There can also be a second type of out-of-office experience where they're enhancing therapeutic effectiveness. It's like when we attend a school play, we go on a tour with an architect of his or her houses, we play basketball with adolescents, or we attend a wedding.

There is error in some people's thinking, when they confuse attending a wedding as a dual relationship. Attending a wedding does not constitute a secondary relationship, but it is rather an out-of-office experience and boundary crossing.

The third type of out-of-office experience is when we have dual relationships in the community, which is very normal in small rural communities and other communities like a church community or minority communities, liek Serbian community in big towns, whether it's LA, Chicago, or New York.

The fourth type of out-of-office experience is when we accidentally encounter our clients on the streets, in the mall, on college campuses.

The last type of boundaries I would like to discuss is dual or multiple relationships. This type of boundary refers to any situation where multiple roles exist between the therapist and a client. Examples of dual relationships are when a client is also a student, a friend, a family member, an employee, a business associate, co-investor, co-author, or lover.

There are different types of dual relationships that can be social (when the client is a friend). There can be professional (when the client is a colleague), it can be a business

dual relationship, communal dual relationship, forensic dual relationship (when a therapist is an expert witness as well as evaluator as well as a therapist; not advised, but it's part of a dual relationship), sexual dual relationship (unethical and illegal in most states), and there are other interesting and complex dual relationships that include, for example, adoption where some therapists choose to attempt to adopt clients after they finish doing therapy with them.

Dual relationships can be voluntary and avoidable. That usually happens in large metropolitan areas, in large cities, etc. Dual relationships can be unavoidable in small towns, in small communities. The idea is that unavoidable dual relationships are only in very small rural areas is not correct, because they're often unavoidable, for example in LGBT communities such as downtown San Francisco, or in a church community in downtown Chicago, or in a Hispanic community in downtown or in LA. So, it's not always in small rural communities that dual relationships are unavoidable. They are unavoidable in college towns, they're an unavoidable part of sport psychology or organizational development.

Then there are dual relationships that are mandated, for example in the military. When I see a client as a psychologist in the military, my actual client is not a client but the Ministry of Defense, so I have a dual loyalty here. In prison, a prison psychologist or mental health worker also has a mandatory dual role because they are mental health workers as well as prison guards. Police psychologists often have a dual role which is mandated as well. So, there have been unavoidable, mandated.

The third type is unexpected type of dual relationship. That's when you bump into your client or, as you saw in the movie *Prime*, when the therapist's son dated the client unbeknownst to the therapist.

Dual relationships can be sequential or concurrent. Concurrent dual relationship, or simultaneous dual relationship, is when the therapist is also a friend at the same time that he or she provides therapy; when the therapist and client attend the same church, club, church, or the same gym at the same time that therapy takes place; or when therapist and client participate in the same professional organization or professional conference, as often happens among therapists. Sequential dual relationship, or chronological dual relationship, is when the friendship starts after termination of therapy. That means it was first therapy, then friendship. Therapists becoming business coaches after termination or therapist playing tennis, or attending church with a client prior to starting of therapy would be a sequential dual relationship.

There are different levels of intensity of dual relationship. It can be very low and minimal involvement, for example, shopping in the same store where the client shops. The medium level, for example, might be when the therapist attends church every Sunday where the client attends church as well, or attending a political rally with their clients. There is a much more intense level of involvement when, for example, the therapist and client play in the same recreation league or serve on any kind of committee together.

Next I would like to cover a few faulty beliefs about boundary crossing in psychotherapy. The first one in boundary crossing almost always leads to boundary violation. This is really paranoid thinking that an innocent hug always leads to intercourse, or that a simple bartering of services leads to a business relationship.

The second myth, or faulty belief, that has been very prevalent in our field is that non-sexual touch is the first step on the slippery slope towards a sexual relationship. The response to that? Only the culture that sexualizes most relationships would not embrace the basic human and proven fact that a hug is a basic human way of greeting, relating, connecting, or soothing human beings.

The third myth is that dual relationships are always unethical. There is a commonly held belief that somehow dual relationships not only lead to sex and exploitation, but they are also unethical. This is completely untrue. The CAMFT code, ACA Code, and ASWB Code are all very similar to the APA Code of Ethics of 2002 and the later code of 2016 that states that multiple relationships that would not reasonably be expected to cause impairment or risk of exploitation, or harm are not unethical. In other words, all these codes acknowledge that some dual relationships directly or indirectly are unavoidable and not all dual relationships are unethical.

The next myth is that risk-management is the same as Standard of Care. It's very important for us to understand that risk-management is about avoiding the appearance of wrong-doing and that Standard of care is a legal term that is based on how reasonable-average-prudent clinicians act in certain situations.

One more myth that we have in our field that I've mentioned earlier is that attending a client's wedding, a play, or confirmation, constitutes a dual relationship. It doesn't.

The biggest myth of all in our field is a myth of the slippery slope. It has been defined as the feeling that the crossing of one boundary leads to the obvious catastrophe; catastrophic results make it easier to cross the next boundaries. The slippery slope is really slippery thinking. It's confuses sequential versus causal relationships. It's nonsensical. It's paranoid and unscientific. It's based on the faulty idea that therapists cannot control themselves and want to touch a client in any form, which somehow leads to the slippery slope. It somehow leads into a sexual and exploitative sexual relationship. There's no scientific proof for the slippery slope phenomenon.

The next myth is the myth of the power differential, that within psychotherapy there is an idea that's always inherent-the power differential or imbalance of power; that all our clients are vulnerable and dependent. The fact is, there are many types of powers, and some of the powers that we as therapists have are legitimate powers, the power of expertise, and we sometimes have coercive power. Our clients are sometimes more charismatic than us. Some of them are more experts than we are. Sometimes they are more powerful than we are. It is important for all of us to remember what one of my colleague's attorney reminded us of, that we are all one borderline away from losing our practices. So, there are different kinds of powers and sometimes we therapists have

more power in the relationship and sometimes we don't. Expert power, legitimate power, coercive power, reference power, reward power, personal power… we need to know that not all clients are vulnerable and not all therapists have extreme coercive power over the client.

Before we end this presentation, I would like to go back to the idea of the context of therapy. The application and the meaning of each of the boundaries that I discussed today can only be understood within the context of therapy. Sometimes touch is the best thing to do to our clients who are anxious in the midst of panic attack. Sometimes it's the last thing that one wants to do with the client who has strong sexual transference to the therapist. Sometimes leaving the office is the best thing to do with a borderline client. Sometimes with the borderline client, it's very important to have reasonable good boundaries. So leaving the office may not be a good idea. In other words, it all depends on the context. What is a context of therapy? It involves the type of client, the type of setting. What's appropriate in the military or in a small community college may not be appropriate in a practice in downtown New York.

Therapy factors of orientation are very important if you are practicing as a humanist, or feminist, or existentialist, or group therapist. Perhaps you have a high emphasis on self-disclosure. This is not the case for psychodynamic or psychoanalytic psychotherapists.

When we talk about a therapeutic relationship, the application of boundaries in therapy, it depends. Do you have a long-term dual relationship? Is it a dual relationship or not dual relationship?

The last factor is a therapist factor, depending on the therapist's training, orientation, and culture. It's very important for the therapist to feel comfortable with the boundary crossing that he or she has employed. What's the level of comfort in regard to transparency? What's the level of comfort about practicing out of home, about gifts, about personality, and culture, training, and orientation of the therapist?

A few words about the historical shift in attitude towards boundaries within the field of psychotherapy and counseling. In the early years, Freud and the analysts had very loose boundaries to start with. They analyzed their patients on vacation, in hotel rooms, went for walks with them, exchanged gifts, analyzed their children. Then in the 60s and 70s, the Humanistic movement and the Civil Right movement, the Secular revolution, and what happened in the Gestalt Institute in Esalen, gave boundaries some wrong names as there was a lot of transgression within this period. It was part of the cultural shift. Then came, in the 80s and early 90s, a backlash, and terms like the slippery slope and the depravity of dual relationships were introduced. There was a change in the mid-90s towards the end of the century, when people realized that in the military and in rural communities dual relationships were unavoidable. Finally, we got into a new era, and in the new millennium we have a much broader understanding of the importance of boundaries and the fact that dual relationships are a part of healthy small communities, and the importance of touch, the acceptance of gifts, as well as transparency, especially now with the Internet.

So, we see part of the shift, APA shift with its Code, and in 2002 with wider acceptance of bartering, and clarifying even further that not all dual relationships are unethical. In 2005 ACA revised its Code to have a wider acceptance also on bartering as well as dual relationships.

In summary, what's most important for us to realize is that we are here to serve our clients. Not acting out of fear or risk-management principles, but to integrate our knowledge, integrate our expertise and integrity towards the welfare of our clients.

If you're interested in the topic of boundaries, there are dozens of articles and even many more online courses on the issues of boundaries, gift, touch, out-of-office experience, dual relationship, ethical risk management, etc. on my website at www.zurinstitute.com.

Thank you.