MAINTAINING APPROPRIATE PROFESSIONAL BOUNDARIES

PRESENTED BY CONTINUING PSYCHOLOGY EDUCATION INC.

3 CONTINUING EDUCATION CONTACT HOURS

A willingness to be honest in your self-examination is your greatest asset in becoming an ethical practitioner (Corey et al. 2019).

Course Objective
The purpose of this course is to provide an understanding of the concept of professional boundaries as related to mental health professionals. Various standards within the Code of Ethics are presented along with commentary and case scenarios which support the standards. Major topics include: the nature of dual relationships, importance of setting professional boundaries, bartering for professional services, giving or receiving gifts, social relationships with, and sexual attraction to clients, legal and ethical issues regarding sexual relationships and nonerotic touching with clients, and New York State laws, rules, regulations, and ethical principles.

Accreditation
Continuing Psychology Education Inc. is recognized by the New York State Education Department's State Board for: Social Work as an approved provider of continuing education for licensed social workers #SW-0387; Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors #MHC-008; Licensed Marriage and Family Therapists #MFT-0043; and Psychology as an approved provider of continuing education for Licensed Psychologists #PSY-0006.

Mission Statement
Continuing Psychology Education Inc. provides the highest quality continuing education designed to fulfill the professional needs and interests of mental health professionals. Resources are offered to improve professional competency, maintain knowledge of the latest advancements, and meet continuing education requirements mandated by the profession.

Learning Objectives
Upon completion, the participant will be able to:
1. Discuss ethical concerns that may result from entering into a dual relationship.
2. Recognize behaviors that can create dual relationships.
3. Identify the reasons most legal professionals look down on the practice of bartering.
4. Acknowledge the importance of setting professional boundaries.
5. Assess whether receiving client gifts is clinically recommended.
6. Articulate several reasons that discourage becoming socially involved or friends with former clients.
7. Understand the need to monitor personal feelings given sexual attraction to a client.
8. Realize legal and ethical issues involving sexual relationships with clients.
9. Acknowledge New York State laws, rules, regulations, and ethical principles.

Director of Operations
Richard Shuman, LMFT
Consultants
Kathryn Wright, LCSW
DeAnne Brining, RN
Dorothy Crawford, Ph.D.

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DUAL RELATIONSHIPS

Mental health professions have authorized guidelines, commonly cited as "boundaries" that serve to address ethical concerns that may arise when dual relationships (also termed multiple relationships) occur between practitioner and clientele.

Dual relationships arise when professionals assume two or more roles simultaneously or sequentially with a client, or with another person who is close to the client. Ethical concerns may result and must be considered when practitioners blend their professional relationship with a nonprofessional relationship with a client because these scenarios may blur the best interests of the client.

Multiple relationships may involve enacting more than one professional role (i.e., therapist and supervisor) or blending a professional and nonprofessional relationship (e.g., therapist and friend or therapist and business partner). Other types of dual relationships include providing therapy to a relative or a friend's relative, socializing with clients, becoming emotionally or sexually involved with a current or former client, engaging in a business relationship with a client, borrowing money from or lending money to a client. Dual relationships or boundary crossings increase the chance that practitioners might misuse their power to influence or exploit clients for their personal benefit and to clients' disadvantage (Zur, 2007). It is good practice to avoid crossing boundaries or enacting dual relationships, however, it is not always possible.

The ethics codes of the mental health organizations define and address a multiple relationship as follows:

A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person (APA, 2017, 3.05.a.).

(a) A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists. Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical. (b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code. (c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur (APA, 2017, 3.05.).

Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively) (NASW, 2021, 1.06.c.).

Counselors consider the risks and benefits of extending current counseling relationships beyond conventional parameters. Examples include attending a client's formal ceremony (e.g., a wedding/commitment ceremony or graduation), purchasing a service or product provided by a client (excepting unrestricted bartering), and visiting a client's ill family member in the hospital. In extending these boundaries, counselors take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no harm occurs (ACA, 2014, A.6.b.).

CMHCs make every effort to avoid dual/multiple relationships with clients that could impair professional judgment or increase the risk of harm. Examples of such relationships may include, but are not limited to, familial social, financial, business, or close personal relationships with the clients (AMHCA, 2020, A.3.a.).

Marriage and family therapists are aware of their influential positions with respect to clients, and they avid exploiting the trust and dependency of such persons. Therapists, therefore make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken (AAMFT, 2015, 1.3).

Codes of Ethics provide general guidelines, in addition, ethical practitioners exercise good judgment, interest in reflecting on their practices, and awareness of their motivations. Herlihy and Corey (2015) advise mental health practitioners to effectively and ethically manage multiple relationships, including understanding the power differential that abounds in most professional relationships, managing boundary issues, and avoiding the misuse of power. Conversely, mental health practitioners may unintentionally overlook: a) warning signs or slippery slopes in their relationships with clients, b) possible issues involved in creating and maintaining professional boundaries, c) implications of their actions, and d) when they are exhibiting unprofessional or problematic conduct.

The Codes of Ethics warn of the potential problems of multiple relationships. These codes advise professionals against any involvement with clients that may diminish their judgment and objectivity, impair their rendering effective services, or culminate in harm or exploitation of clients - such is deemed unethical. In contrast, the Codes of Ethics indicate that nonsexual multiple relationships are not inherently unethical and that some multiple relationships are unavoidable. Upon considering a multiple relationship, mental health professionals are advised to examine their motivations and consult with other professionals to assess the appropriateness of the relationship. Corey, Corey, and Corey (2019) recommend practitioners to be cautious about enacting more than one role with a client unless sound clinical justification supports such a decision, and to implement measures to reduce the likelihood of client harm. Further, it is advised to document precautions that were taken to protect clients when multiple relationships are unavoidable.

Moleski`and Kiselica (2005) believe multiple relationships range from destructive to therapeutic; some can cause harm while other secondary relationships may enhance the therapeutic relationship. These researchers advocate carefully examining potential positive and negative consequences that a secondary relationship may have on the

primary therapeutic relationship, and to only consider a multiple relationship when it is clearly in the best interest of the client.

Younggren and Gottlieb (2004) recommend that clinicians consider these questions to make responsible decisions about multiple relationships:

1. Is entering a relationship in addition to the professional one necessary, or should I avoid such?
2. Can the multiple relationship potentially be harmful to the client?
3. If harm is unlikely, would the additional relationship be beneficial? If deemed beneficial, is the benefit focused more on the client, therapist, or both?
4. Can the secondary relationship hinder the therapeutic relationship?
5. Can I be objective in my evaluation of this situation?

Evaluation of the above five questions must assess the risk for conflict of interests, loss of objectivity, and ramifications for the therapeutic bond. It is good practice to converse with client about potential concerns inherent in a multiple relationship.

If the multiple relationship is considered appropriate, therapist should document the entire process and have client sign an informed consent form. Additionally, maintaining a risk management approach to multiple relationships is recommended which includes review of various issues such as diagnosis, level of functioning, therapeutic orientation, community standards and practices, and consultations with professionals who support the decision. Younggren and Gottlieb offer this advice: "Only after having taken all these steps can the professional consider entering into the relationship, and he or she should then do so with the greatest of caution" (p.260).

Barnett et al. (2007) suggest following these guidelines to confirm the client's best interests are being served:

a) Therapist is motivated by client's needs rather than her or his own needs.
b) The boundary crossing is congruent with client's treatment plan.
c) The client's diagnosis, history, values, and culture have been reviewed.
d) Therapist documents the rationale for the boundary crossing in client's record.
e) Practitioner discusses the boundary crossing with client in advance to avoid misunderstandings.
f) Clinician considers the power differential and ensures client's trust is protected.
g) Therapist consults with colleagues for objective guidance.

Examples of behaviors that can create dual relationships include accepting a client's invitation to a special event such as a graduation or wedding, bartering goods or services for professional services, accepting a small gift from client, attending the same social, cultural, or religious activity as the client, or giving a supportive hug after a challenging session. Gutheil and Gabbard (1993) advise that engaging in boundary crossings can result in boundary violations and becoming entangled in complex dual relationships. They note the difference between boundary crossings (changes in role) and boundary violations (client exploitation at some level) by stating: "A boundary crossing is a departure from commonly accepted practices that could potentially benefit clients; a boundary violation is a serious breach that results in harm to clients and is therefore unethical." These researchers acknowledge that all boundary crossings are not boundary violations and that interpersonal boundaries may change over time as therapist and client continue the therapeutic relationship. Behaviors that extend boundaries, however, may become problematic, and boundary crossings can culminate in a tendency to blur professional roles. Measures must be taken to prevent boundary crossings from becoming boundary violations.

Therapist self-disclosure is a common type of boundary crossing. Lengthy clinician self-disclosure may not be of benefit to client whereas many theoretical models do advocate timely and appropriate therapist disclosure if in the service of client. Therapist self-disclosure should not be burdensome to client or make client feel the need to nurture therapist. Clinicians need to consider factors such as client's history, the presenting issue(s), cultural factors, client's comfort level with therapist disclosing information, and therapist's own level of comfort with disclosing. Therapists are advised to understand their reasons and motivations for sharing personal experiences or reactions in a therapy session.

Barnett et al. (2007) state that deliberate reflection is required to determine when crossing a boundary ends in harm to client, even for conscientious practitioners. It is a boundary violation if therapist's actions result in client harm. Failure to practice in accord with community standards, and other variables such as client's history, values, and culture can result in well-intended actions being perceived as a boundary violation. Pope and Vasquez (2016) warn that crossing a boundary involves risk: "Done in the wrong situation, or at the wrong time, or with the wrong person it can knock the therapy off track, sabotage the treatment plan, and offend, exploit, or even harm the patient" (p. 253). Barnett (2017a) advises that "one client's boundary crossing may be another client's boundary violation" (p. 27) and therapists are wise to discuss dual relationships concerns within the informed consent process. Contrarily, Barnett adds that crossing boundaries may be therapeutic and appropriate in some cases, and avoiding crossing some boundaries can be counterproductive against the therapeutic relationship. Likewise, Pope and Vasquez (2016) mention that not engaging in a particular boundary crossing may be a lost opportunity that can harm the therapeutic relationship. For example, a therapist refusing to accept client's small, self-created painting may result in client feeling rejected, or client may be offended if giving gifts is customary in her or his cultural tradition.

Having consistent and flexible boundaries is generally therapeutic and can foster client trust in the therapy alliance. Smith (2011) recommends a balanced therapeutic

relationship that is not too tight or too loose. Smith contends that appropriate boundaries offer "both patient and therapist freedom to explore past and present, conscious and unconscious, fact and fantasy. Boundaries offer safety from the possibility of rule by impulse and desire" (p. 63).

Some job descriptions of mental health professionals inherently involve multiple roles, for instance, school psychologists may serve as instructor, supervisor, mentor, or therapeutic agent. This situation is termed *role blending*, defined as combining roles and responsibilities. Role blending is not necessarily unethical, however, the professional must avoid exploitation, loss of objectivity, or conflicts of interest. Working in more than one role requires contemplating potential issues before they occur and implementing safeguards into practice. In situations where potential for negative outcomes abounds, professionals have a responsibility to create safeguards designed to prevent client harm.

Professionals are likely to encounter trouble if they inadequately define their boundaries, and blend roles that do not mix (i.e., professional and social roles). Allowing boundaries to slowly deteriorate can lead to problematic dual relationships that harm clients. Gutheil and Gabbard (1993) and Gabbard (1994) point to the *slippery slope phenomenon* as a reason to monitor therapeutic boundaries. The crossing of a boundary can result in a tendency to employ a number of increasingly serious boundary violations promoting progressive degradation of ethical behavior. Not abiding by advised standards of practice may create relationships that are harmful to clients.

Herlihy and Corey (2015b) identify the following major themes pertaining to multiple roles:

1. Most mental health practitioners encounter multiple relationship issues, regardless of their place of work or clientele.
2. Most professional codes of ethics caution mental health practitioners about possible exploitation inherent in dual relationships, and the codes affirm the complex nature of multiple relationships.
3. Not all boundary crossings and multiple relationships can be averted, and they are not always harmful; they can be of benefit.
4. Multiple role relationships stimulate self-monitoring and examination of practice motives.
5. Pursue consultation with trusted colleagues, a supervisor, or your professional organization when considering engaging in a dual relationship; document the nature of the consultation.
6. Few standardized answers abound to easily resolve multiple relationship dilemmas.
7. Exerting caution about exercising multiple relationships should be for the client's benefit and not for therapist to self-protect against censure.
8. In assessing entry into a multiple relationship, examine if the potential benefit exceeds the potential for harm. When possible, include client in the decision-process.

Zur (2007) noted the historical perspectives on professional boundaries. Issues regarding therapeutic boundaries arose in the 1960s and 1970s due to extensive lack of regard for boundaries by many mental health professionals and the subsequent client exploitation. The culture at large and the mental health professions pressured for specific guidelines for appropriate and ethical conduct in the field of psychotherapy. Increased injunctions against boundary crossing and greater priority for risk management practices developed in the 1980s. Most boundary crossings and multiple relationships were heeded from a risk management perspective as perils to be avoided.

A change in thinking about therapeutic boundaries emerged in the 1990s in that some boundary crossings (e.g., therapist self-disclosure, nonsexual touch) can be clinically beneficial. Some ethics codes addressed themes such as appropriate therapeutic boundaries, potential conflicts of interest, and ethical and effective ways of managing dual relationships.

Herlihy and Corey (2015b) assess the current perspective on multiple relationships as follows: "The absolute ban on multiple relationships has been replaced with cautions against taking advantage of the power differential in the therapeutic relationship and exploiting the client, while acknowledging that some boundary crossings can be beneficial. Many professionals now agree that flexible boundaries can be clinically helpful when applied ethically and that boundary crossings need to be evaluated on a case-by-case basis."

Barnett (2017a) believes that maintaining a rigid risk-avoidance perspective on boundaries can create a sterile relationship that can hinder developing a positive therapeutic alliance. Examples of rigidity include avoidance of touching clients under any circumstance, refusing any small gift, or never extending a session for any reason.

Corey et al. (2019) advise therapists to: a) assess their client population regarding age, diagnosis, life experiences, such as abuse, and culture when instituting boundaries; and b) consider the therapist's own character and values relating to how boundaries were structured in their family of origin and how they are managed in their current personal life. Developing and maintaining appropriate boundaries in our personal lives will likely generalize to establishing appropriate boundaries in our professional lives.

Managing multiple relationships in small communities is often necessary for mental health professionals. Practitioners in rural settings are commonly involved in dual relationships (Barnett, 2017b) by balancing the roles of clinician, neighbor, friend, and other possible community interactions such as a member of various boards, religious group, or educational consultant (Bradley, Werth & Hastings, 2012).

Bray (2016) believes that practitioners experience challenges that are inherent in rural areas by acknowledging, "Rural counseling is anything but the neat-and-tidy model in which a practitioner sees each individual client one hour per week in a single office" (pp. 33-34). Barnett (2017b) asserts that the goal for rural therapists is not avoiding all multiple roles and relationships, instead, it is managing such relationships in an ethical and mindful manner.

Schank et al. (2010) recommend the following for practitioners in small communities to practice ethically and professionally and minimize risk:

a) Acquire informed consent
b) Document thoroughly
c) Establish clear boundaries and expectations for yourself and your clients
d) Monitor confidentiality matters
e) Participate in ongoing consultation or a peer supervision group

Corey et al. (2019) offer the following case study of a dual relationship in a small community:

Mary, a small community therapist, felt heart pain one day. The fire department was called and the attending medic happened to be her client, John. John had to remove Mary's upper clothing to conduct proper medical care. Mary nor John discussed the incident in subsequent sessions but both felt some discomfort with each other. John discontinued his therapy after several more sessions.

Analysis: This case demonstrates how roles can change and how some multiple relationships are inescapable, notably in small communities where therapists need to anticipate boundary crossings with clients. During the informed consent process, Mary should have asked John how he would like to manage chance community encounters. Mary could have potentially maintained the therapy relationship by disclosing her own uneasiness with a colleague and then process the event with John. By perpetuating the hidden agenda, Mary did not practice with her client's best interest as the intent. Consequently, therapist's and client's needs were not being fulfilled in the therapeutic relationship.

Whereas certain boundary crossings in an urban area are not recommended, these same actions may be unavoidable or even mandatory in rural areas. Nonetheless, rural practitioners must act ethically, hence, their requirement of managing boundaries is more challenging and they are advised to consider the best interests of their clients.

BARTERING for PROFESSIONAL SERVICES

When a client cannot afford therapy, the option of a bartering arrangement could arise, which is the exchange of goods or services instead of paying the standard fee for psychological services. For instance, an automobile mechanic may exchange working on the therapist's car for therapy sessions. Unfortunately, this arrangement can lead to client resentment if the car repair occupies more hours than the provided therapy, or therapist resentment can surface if the car was not repaired correctly. Issues may also arise when clients perform personal work for the therapist such as secretarial services or cleaning therapist's home; client may feel exploited as personal information about therapist is uncovered. These scenarios can damage the therapeutic alliance.

When considering bartering, therapist and client are advised to thoroughly discuss the arrangement, understand the nuances of the exchange, discuss problems that can develop and additional alternatives, and reach an agreement. Therapist will assess client's needs, situation, and cultural background when deciding upon a bartering arrangement. Zur (2011a) proposes that bartering can be a dignified form of payment for people lacking in funds but talented in other ways. Corey et al. (2019) claim "If bartering is done thoughtfully and in a collaborative way, it can be beneficial for many clients and can enhance therapeutic outcomes." These same researchers also note that using a sliding scale to determine fees or referring client elsewhere are viable options.

Barnett and Johnson (2008) and Koocher and Keith-Spiegel (2016) believe that bartering arrangements with clients can be humanitarian when people need psychological services but lack insurance coverage and finances. Corey et al. (2019) emphasize that:

a) bartering entails risks, hence, thoughtfully assessing the bartering arrangement beforehand is important.
b) Practitioners are advised to seek consultation from a trusted colleague who can objectively evaluate the proposed bartering arrangement concerning equity, clinical appropriateness, and the risk of potentially harmful dual relationships.

Thomas (2002) proposes that venturing into a dual relationship necessitates deliberate thought and judgment. The primary factor is enacting the "higher standard" of considering the welfare and best interests of the client. Thomas recommends having a written contract that details the nature of the agreement and regularly reviewing and, if needed, updating the contract. Documenting the bartering arrangement can serve to clarify the agreements and assist professionals in defending themselves if required.

The ethics codes on bartering indicate the following:

APA Ethical Principles of Psychologists and Code of Conduct (2017): Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative (APA, 2017, 6.05).

Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship (NASW, 2021, 1.13.b.).

Counselors may barter only if the bartering does not result in exploitation or harm, if the client requests it, and if such arrangements are an accepted practice among professionals in the community. Counselors consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract (ACA, 2014, 10.e.).

CMHCs usually refrain from accepting goods or services form clients in return for counseling services, because such arrangements may create the potential for conflicts, exploitation, and distortion of the professional relationship. However, bartering may occur if the client requests it, there is no exploitation, and the cultural implications and other concerns of such practice are discussed with the client and agreed on in writing (AMHCA, 2020, E.2.a.).

Marriage and family therapist ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if: (a) the supervisee or client requests it; (b) the relationship is not exploitative; (c) the professional relationship is not distorted; and (d) a clear written contract is established (AAMFT, 2015, 8.5).

Barnett and Johnson (2008) assert that, as a general rule, it is not wise to enact bartering practices with clients. They believe that accepting goods or services for professional services can lead to misunderstandings, actual or perceived exploitation, boundary violations, and diminished clinician efficacy. Though bartering is not prohibited by law or ethics, most legal professionals look down on the practice. Woody (1998), a psychologist and attorney, rejects the practice of bartering for psychological services and suggests it is below the minimum standard of practice. Upon entering a bartering agreement, Woody reports that therapist will have the burden of proof to show that the bartering arrangement: a) supports the best interests of client; b) is reasonable, equitable, and initiated without undue influence; and c) does not interfere with providing quality psychological services. Woody advises bartering only as the option of last resort because it involves risks to therapist and client.

An economic crisis can stimulate more frequent bartering requests, as such, Corey et al. (2019) offer these guidelines for bartering arrangements if exercised:

1. Determine the value of the goods or services with client at the beginning of the bartering arrangement.
2. Estimate the length of time for the entire barter arrangement.
3. Document the bartering arrangement, and include the value of all goods and services and the date on which the arrangement will end.
4. Consult with experienced colleagues and your professional organization if you are pondering bartering instead of traditional payment for services.

It is therapist's responsibility to have a straightforward discussion with client regarding the possible problems and risks of bartering because client may be unaware of potential conflicts. Therapist may want to consult with a third party about the value of a fair market exchange, with a contract attorney about the agreement, and with colleagues pertaining to alternatives that therapist and client may not have assessed.

Corey et al. (2019) offer the following bartering case study:
Case 1 - Client is 20 years old and has been in therapy for about one year. She respects her therapist and views him as a father figure. Client informs therapist that she lost her job and cannot pay for continued therapy. Therapist states he will provide therapy without pay and suggests client can become the babysitter for his three children as an exchange of services. She accepts the offer but after several months feels that the situation is too difficult for her. Client writes a note to therapist saying she cannot manage her reactions to therapist's wife and children because it arouses feelings of all she missed in her own family. She writes the subject has been difficult to disclose in therapy and she plans to quit babysitting services and her therapy.

Analysis - A well-intentioned therapist created a multiple relationship with his client by suggesting a bartering arrangement involving exchange of personal services for therapy that became a problem for client. Generally, it is unwise for therapists to include their significant others in barter exchanges with clientele. Therapist did not explore client's transference feelings for him, or possible issues stemming from client taking care of his children. Possibly, therapist countertransference may have resulted in the blurring of boundaries. The APA ethics code (6.05, stated above) professes that psychologists may barter only if (1) it is not clinically contraindicated; the ethics codes of NASW (1.13.b.), ACA (10.e.), AMHCA (E.2.a.), and AAMFT (8.5) (stated above) require client to request/initiate bartering and this standard was not met in this case. Therapist should have considered other alternatives, for example, working pro bono, lowering his fees, or referring to another agency.

GIVING or RECEIVING GIFTS

Accepting expensive client gifts is considered potentially problematic and unethical. Conversely, the policy of refusing any and all gifts can possibly damage the therapeutic relationship. An option for therapists is to have their informed consent document include their policy on accepting gifts from clients. Corey et al. (2019) prefer an evaluation of each situation on a case-by-case basis rather than a predetermined rule based on some relevant questions as indicated below:

1. *What is the value of the gift in dollars?* Neukrug and Milliken (2011), for example, observed that the gift value was important to therapists, specifically, 88.3% thought accepting a gift from client valued at more than $25 is unethical, and 94.7% believed that a therapist gift to client worth more than $25 is unethical.

The novel, *Lying on the Couch,* by Yalom (1997) told of a therapist being offered a $1600 bonus by a wealthy client for appreciation of several therapy sessions that changed his life. Therapist initially struggles but does decline the gift and informs client it is unethical to accept a monetary gift from a client. Client angrily proclaims that rejecting his gift might negate some of his therapeutic gains and demands the score be evened. Therapist firmly responds he cannot accept the gift, and wisely, acknowledges that a topic not discussed in therapy was client's uneasiness in accepting help.

A client offering tickets to a sporting event or theater and requesting therapist to accompany client would also be problematic.

Therapists who are opposed to receiving gifts and believe this is a boundary crossing may consider addressing this issue in the informed consent document.

2. *What clinical implications are involved in accepting or rejecting the gift?* Therapist is advised to recognize when accepting a client gift is clinically contraindicated and be willing to discuss the matter with client. Knowing client's motive for gift-giving is essential in deciding acceptance or rejection of the gift. A client may be seeking therapist

approval, thus, motivation for gift-giving is to please therapist. In this case, accepting the gift without discussion would not be helpful in the long-term. In fact, clinicians may even ask client the meaning of small gifts. Zur (2011b) proposes that: a) any gift must be evaluated and understood within the context that it is given; b) inappropriately expensive gifts or gifts creating indebtedness, either of client or therapist, are boundary violations; and c) appropriate gift-giving can improve therapeutic effectiveness and be considered a healthy aspect of the therapist-client rapport.
3. *When during the therapy process was the gift offering made?* Accepting a gift during early stages of therapy can be more problematic than at the end of therapy because the former can lead to establishing lax boundaries. A gift at therapy end might have symbolic or cultural value for the client.
4. *What are therapist's motivations for accepting or rejecting client's gift?* Therapist must acknowledge whether it is therapist's or client's needs being fulfilled by receiving a gift. Reasons for therapist's gift acceptance may range from intent to not hurt client's feelings, inability to set firm and clear boundaries, to desire for receipt of the gift. A gift may be productive to therapy in appropriate conditions, therefore, therapist will need to assess the meaning of the gift.
5. *What are the cultural implications for offering the gift?* The cultural context is a factor to consider when determining the appropriateness of accepting client's gift. Sue and Capodilupo (2015) cite the Asian cultures in which gift-giving is a common practice revealing respect, gratitude, and the sealing of a relationship. Contrarily, Western-trained practitioners may feel that accepting a gift would distort boundaries, change the relationship, and possibly produce a conflict of interest. Therapist's refusal of a gift might insult or humiliate client and damage the therapeutic alliance and the client. Zur (2011b) asserts that most clinicians believe that refusing appropriate gifts of small monetary value but significant relational value can offend clients and negatively impact the therapeutic relationship. Practitioners may want to include their position on this issue in the informed consent document.

The ethics codes on accepting gifts cite the following:

Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and gratitude. When determining whether to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift (ACA, 2014, A.10.f.).

When accepting gifts, CMHCs take into consideration the therapeutic relationship, motivation of giving, the counselor's motivation for receiving or declining, cultural norms, and the value of the gift (AMHCA, 2020, E.2.c.).

Marriage and family therapists attend to cultural norms when considering whether to accept gifts from or give gifts to clients. Marriage and family therapists consider the potential effects that receiving or giving gifts may have on clients and on the integrity and efficacy of the therapeutic relationship (AAMFT, 2015, 3.9).

Corey et al. (2019) offer the following gift-giving case study:

Case 1 - Near termination of therapy, client presents an expensive jewelry item to therapist and states the gift, which has been in her family for a long time, represents gratitude for all the therapist has done for her. Client claims that giving gifts is an important part of her Japanese culture. Therapist kindly discloses he would like to accept the gift but his policy is not to accept gifts from clients and he reminds client that this policy is included in the informed consent document which she signed at the beginning of therapy. Client insists that therapist accept the gift, otherwise, she will feel rejected. Client is very grateful for her productive therapy and giving this gift expresses her appreciation. Therapist remembers that in a previous session, client reported that gifts in her culture are given with the expectation of reciprocity. Several days after this session, therapist received a client invitation to attend her daughter's birthday party where her family would be in attendance.
Analysis - Therapist was explicit about his policy of not accepting gifts, which was clearly stated in his informed consent document, and he acknowledged that client accepted this guideline. To assist therapist in understanding the meaning of the gift-giving gesture and avoid misunderstanding client's hope that he accept the gift, therapist could open discussion about the importance and meaning the gift has for her, including the cultural implications of her offering the gift. Practitioners must assess cultural influences and implications in professional relationships, yet therapist should not yield to a culture-based request that could be harmful to client or the therapeutic alliance. Regarding client's invitation to her daughter's birthday party, therapist is advised to consider his response to such future requests from this client and similar requests from other clients.

SOCIAL RELATIONSHIPS WITH CLIENTS

Mental health professionals are not legally or ethically prohibited from establishing nonsexual relationships with clients upon therapy termination. Creating friendships with former clients, however, may become problematic for therapist and client. Several reasons that discourage becoming socially involved or friends with former clients include: 1) therapist may not challenge client to the full extent due to the need to be accepted and liked by client; b) therapists' objectivity may be hampered if their personal needs become enmeshed with client's needs; and c) exploitation of client is more likely because of the power differential inherent in the therapeutic relationship; as a consequence, client could feel taken advantage of which could result in a complaint against therapist. Responsibility lies with therapist to assess the potential effect of entering into such relationships.

Corey et al. (2019) acknowledge that forming friendships may not be unethical or illegal but the practice can create problems, hence, the safest policy is avoiding forming social relationships with former clients. Former clients may need therapy in the future but if therapist developed a friendship with the former client then that client is not eligible to use the befriended therapist. Within the social relationship, the

imbalance of power may remain a constant resulting in client still perceiving former therapist as a current therapist or former therapist may still behave as a therapist. Mental health professionals need to be aware of their own motives, and the client's motives when allowing a professional relationship to become a personal one, despite therapy having ended. An objective viewer can question the motivation of practitioners who rely on their professional position to fulfill their social needs. Additionally, therapists who habitually develop relationships with former clients may ultimately feel overextended and resentful of the alliance which either they or client initiated. It is wise for therapists to establish clear boundaries pertaining to what they are willing to do.

Factors to evaluate when considering socialization with former clients include whether the social involvement was initiated by client or therapist; if the social contact is occasional or ongoing; and the amount of intimacy involved. When pondering socializing with a current client, therapist should consider the nature of the social function, the nature of client's issue(s), the client population, therapist's work setting, the type of therapy being implemented, and therapist's theoretical approach. Those who are psychoanalytically oriented, for example, may exercise stricter boundaries to avoid hindering the transference relationship. Evaluate these factors from both the client's and therapist's perspective.

Combining professional and social relationships requires therapist to be honest and self-aware. Despite therapist clarifying boundaries with client, the social relationship should not be formed if client cannot understand or handle the relationship - with current or former clients. The professional and social relationship can deteriorate if clear boundaries are not honored, as evidenced by: a) clients may inhibit their disclosures for fear of alienating therapist; b) clients may become preoccupied with losing therapist's respect with whom they have befriended; and c) clients may censor their disclosures to avoid threatening the social relationship.

SEXUAL ATTRACTIONS TO CLIENTS

In a classic study, Pope, Keith-Spiegel, and Tabachnick (1986) studied 585 therapists and only 77 reported never having been attracted to any of their clients. 82% reported never having seriously considered sexual involvement with a client, and 93.5% reported never having engaged in sexual relations with a client. Therapists shared their reasons for abstaining from acting out their attraction to clients, which included the need to uphold professional values, concern regarding welfare of client, and desire to follow personal values. Fears of negative consequences were reported, but less frequently than values and concerns related to client welfare.

The predisposition to manage sexual feelings as taboo has made it somewhat difficult for therapists to acknowledge and accept their attractions to clients (Pope, Sonne, & Holroyd, 1993). The majority of therapists feel guilty, anxious, and confused when experiencing sexual attraction to a client, despite having no intent to act upon the feeling. Such reactions contributes to many practitioners choosing to hide rather than address sexual feelings in consultation with a colleague or in their own therapy; sufficient training in this area is uncommon (Pope & Wedding, 2014). A survey by Neukrug and Milliken (2011) found that 10.3% of therapists considered it ethical to reveal a sexual attraction to a client and 89.7% thought this was unethical.

A distinction exists between perceiving a client to be sexually attractive versus being preoccupied with the attraction. Therapists are advised to monitor their feelings given sexual attraction to their clients, and to examine this issue in supervision or their own therapy if feeling frequently attracted.

Practitioners need to be aware of how they set boundaries when sexual attraction occurs. Therapists who have issues with setting clear boundaries in their personal life are more likely to have concerns in defining appropriate boundaries with their clientele. It is advised for therapists to recognize their countertransference reactions and manage them to prevent sexual feelings from affecting the therapy process. Burwell-Pender and Halinski (2008) caution that "the potential for sexual impropriety and sexual misconduct is increased with unmanaged countertransference" (43). The therapy process is such that the vulnerability a client reveals when disclosing deep feelings is appealing and powerful, likewise, the attention a therapist gives in response to client's disclosures is also appealing and powerful, and this environment generates the possibility of mutual attraction. Acknowledging these feelings in a safe setting with a supervisor or trusted colleague may facilitate managing these feelings productively.

Some therapists address the issue of sexual attraction during the informed consent process at the first session, possibly due to their own fear of experiencing sexual attraction to clients or the temptation to carry out sexual misconduct. Knapp et al. (2013) warn that therapeutic harm can arise by emphasizing certain rules, such as the following statement, in the informed consent document:
"I recognize that I am here to see Dr. X for professional purposes and that I have no sexual interest in him and will not attempt to involve him in a sexual relationship or even fantasize about him" (p. 375). This practitioner's style "appeared to place the responsibility for sexual misconduct on the patient and to raise it to a level of importance that most patients would never have considered. Such statements could also cause some patients to wonder if this psychologist had issues with personal control over his own impulses" (p. 375).

Corey et al. (2019) offer these two sexual attraction case studies:
Case 1 - You are sexually attracted to a client and you sense client may have similar feelings toward you and may be open to becoming involved with you. Often, you have difficulty staying focused and being attentive during these sessions because of your attraction. Consider which of the options

below is most ethical and which are unethical:

1. I will ignore my feelings for client and client's feelings toward me and focus upon other aspects of the therapeutic relationship.
2. I will inform client of my feelings of attraction, terminate the professional relationship, and initiate a personal relationship.
3. I will disclose my feelings toward client by stating: "I'm flattered you find me an attractive person, and I'm attracted to you as well. But this relationship is not about our attraction for each other, and I'm sure that's not why you are here."
4. I would refer client to another therapist if the intensity of my attraction and feelings toward client did not change.
5. I will consult with a colleague or seek professional supervision.

What other options exist? What would you do and what is your rationale?

Analysis - Therapists need to control their emotional energy without becoming frozen. We can monitor ourselves by examining the messages we are sending to client. We need to acknowledge and manage our feelings toward a client in a manner that does not burden client. Fisher (2004) notes that therapists are responsible to take appropriate steps to manage their feelings in a professional and ethical manner.

Koocher and Keith-Spiegel (2016) encourage therapists to discuss sexual attraction feelings with another therapist, a trusted or experienced colleague, or an understanding supervisor. Such communication can assist therapists to clarify the risks, recognize their vulnerabilities regarding sexual attraction, receive suggestions on courses of action, and provide a fresh perspective on the situation. Practitioners are always responsible for controlling their feelings toward clients, and transferring blame to the client is never an excuse for unethical or unprofessional conduct. Corey et al. (2019) advise therapists not to disclose their feelings of attraction with the client directly because this can interfere with the therapy and may become a confusing burden to client.

Case 2 - Client's husband died and she is working through grief and other issues regarding one of her three children acting out in school. Client seems to rely on therapist as a partner in addressing her son's school issues. Client admits it would be difficult not to see him and that she has grown to love him. She discloses her desire to see therapist socially and romantically.

Therapist is initially surprised by client's response but also realizes he has grown to value her and he discloses his fondness for her. He informs client that due to their professional relationship he must honor ethical guidelines not to become involved with clients socially or romantically. He recommends they not see each other for one year and if their feelings endure then he will consider beginning a personal relationship.

Analysis - Refusing to begin a romantic relationship with client at this time adheres to the ethics codes and therapist is advised to acknowledge the ethical obligations on romantic and sexual relationships with former clients or their family members. The APA (2017) code specifies a 2-year moratorium following termination of services; the ACA (2014) code prohibits such relationships for 5 years after termination; AAMFT (2015) and NASW (2021) prohibit sexual intimacy with former clients regardless of time elapsed. If a therapist commences a romantic relationship in the future with a former client then she or he bears the burden of showing this change in roles was not harmful to client; if the relationship ends, the therapist is not protected given client reporting therapist for professional misconduct.

Specifying our boundaries in the informed consent document may minimize complications in such matters. It is not an ethical violation to grow fond of each other whereas the way we respond to our feelings toward our clients defines our ethical and professional behavior.

SEXUAL RELATIONSHIPS WITH CIENTS: LEGAL and ETHICAL ISSUES

The issue of sexual contact in therapy is not limited to whether sexual intercourse occurred or not, instead, varying degrees of sexuality exist. Clinicians may: a) have sexual fantasies; b) act seductively with client; c) influence client to consider sexual feelings toward therapist; or d) enact physical contact designed to satisfy their own needs. Practitioners must identify the difference between having a sexual attraction and acting on the attraction. We need to be aware of the effects of our sex-related socialization patterns and how they may influence possible countertransference reactions (Corey et al. 2019). Engaging in sexual overtones can distort the essence of the therapeutic alliance and become the main focal point of the sessions.

The ethics codes are explicit regarding sexual relationships with clients, including the prohibition of accepting as clients individuals with whom a prior sexual relationship existed. The ethics codes pertaining to sexual contact with current clients are as follows:

Psychologists do not engage in sexual intimacies with current therapy clients/patients (10.05).

Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard (10.06).

Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies (10.07).

Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced (NASW, 2021, 1.09.a.).

Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers—not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries (NASW, 2021, 1.09.b.).

Sexual and/or romantic counselor–client interactions or relationships with current clients, their romantic partners, or their family members are prohibited. This prohibition applies to both inperson and electronic interactions or relationships (ACA, 2014, A.5.a.).
Counselors are prohibited from engaging in a personal virtual relationship with individuals with whom they have a current counseling relationship (e.g., through social and other media) (ACA, 2014, A.5.e.).
Romantic or sexual relationships with clients and their immediate family members (i.e., parents, children, and partners) are strictly prohibited. CMHCs do not counsel persons with whom they have had a previous sexual relationship (AMHCA, 2020, A.4.a.).
Sexual intimacy with current clients or with known members of the client's family system is prohibited (AAMFT, 2015, 1.4).

The ethics codes pertaining to sexual contact with former clients include the following:

(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy. (b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient (APA, 2017, 10.08)
Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally (NASW, 2021, 1.09.c.).
Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries (NASW, 2021, 1.09.d.).
Counselors are prohibited from engaging in counseling relationships with persons with whom they have had a previous sexual and/or romantic relationship (ACA, 2014, A.5.b.).
Counselor– client interactions or relationships with former clients, their romantic partners, or their family members are prohibited for a period of 5 years following the last professional contact. This prohibition applies to both in-person and electronic interactions or relationships. Counselors, before engaging in sexual and/or romantic interactions or relationships with former clients, their romantic partners, or their family members, demonstrate forethought and document (in written form) whether the interaction or relationship can be viewed as exploitive in any way and/or whether there is still potential to harm the former client; in cases of potential exploitation and/or harm, the counselor avoids entering into such an interaction or relationship (ACA, 2014, A.5.c.).
Counselors consider the risks and benefits of accepting as clients those with whom they have had a previous relationship. These potential clients may include individuals with whom the counselor has had a casual, distant, or past relationship. Examples include mutual or past membership in a professional association, organization, or community. When counselors accept these clients, they take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs (ACA, 2014, A.6.a.).
CMHCs should not knowingly enter into a romantic or sexual relationship with a former client. If a CMHC chooses to enter into such a relationship, the burden to demonstrate that neither coercion nor harm to the client has transpired is on the CMHC and not the former client (AMHCA, 2020, A.4.b.).
Sexual intimacy with former clients or with known members of the client's family system is prohibited (AAMFT, 2015, 1.5).

Most states have declared sexual relationships with clients a violation of the law. Under New York law it is third-degree, or statutory, rape when a mental health provider engages in a sexual relationship with a patient undergoing therapy, regardless of age. A person commits Rape in the Third Degree (NYPL § 130.25) when they engage in sexual intercourse with someone who is incapable of consent. The patient is considered to be unable to consent because his or her emotions have been manipulated by the therapist. Rape in the Third Degree is a non-violent E felony, punishable by up to 14 months to four years in prison. Additionally, the person must register as a sex offender, which often makes many aspects of life more difficult. The societal stigma is the same for someone who was convicted of Rape in the Third Degree and Rape in the First Degree.

Sexual misconduct is a serious ethical violation for therapists, and it is one of the most common allegations in malpractice suits (APA, 2003b). Grenyer and Lewis (2012) reviewed the prevalence of all psychologist misconduct types reported to the New South Wales Psychologist Registration Board over a four-year span. There were 224 complaints filed against the total of 9,489 registered psychologists. The complaints comprised 24 boundary violations of which 10 involved sexual relationships, and 4 involved sexual behavior without a relationship.

Research reveals that clients who are victims of sexual misconduct experience harmful consequences. Erotic contact is completely inappropriate, always unethical, and exploits the therapist-client relationship. Sexual contact between practitioner and client is the most potentially damaging boundary violation. Mental health professionals cannot use as a defense that their client seduced them because, even in cases where client behaved in seductive ways, it is unequivocally the professional's responsibility to set and maintain boundaries. Blaming the client in these cases is equivalently inappropriate as blaming the victim in a rape case.

An early, seminal study of sexual contact in psychotherapy by Bouhoutsos and colleagues (1983) declares that therapy as a helping process ends when sexual intercourse begins; therapist loses control of the therapy process. Their study found that 90% of the 559 clients who became sexually involved with their therapist were adversely affected. Harmful issues spanned from mistrust of opposite-gender relationships to hospitalization to, in some cases, suicide. Other reactions involved negative feelings about the experience, negative effect on their personality, and deterioration of the sexual relationship with their primary partner. Bouhoutsos and colleagues assert that the damage of sexual contact in therapy confirms the ethics codes prohibiting such conduct and offers a rationale for authorizing legislation barring it.

Eichenberg et al. (2010) report that the ramifications of sexual misconduct with therapy patients "are consistent in all international literature: all empirical studies that are available to date show very negative consequences for the victims"

(p. 1019). These researchers found that 86.5% of their study participants experienced consequences due to the sexual contact with their therapist. Within this group, 93.3% experienced harmful effects, including isolation, stronger distrust, fear, depression, feelings of shame and guilt, suicidal tendencies, anger, and posttraumatic stress disorder.

A number of states, including New York, as previously mentioned, have legislated legal sanctions in cases of sexual misconduct within the therapeutic relationship, which makes it a criminal offense. Consequences for therapists include becoming the target of a lawsuit, being convicted of a felony, license revocation or suspension by the state, expulsion from professional organizations, losing insurance coverage, and loss of their jobs. Additionally, therapists may also be placed on probation, be required to enter their own psychotherapy, and be closely monitored and obtain supervised practice if granted permission to resume their practice. Further, their reputation is likely to be affected among their colleagues.

Criminal liability rarely occurs within mental health practice, however, some conduct can result in arrest and incarceration, and the incidence of criminal prosecutions of mental health professionals in increasing. The two main causes of criminal liability are sex with current and former clients, and fraudulent billing practices (Reaves, 2003).

Corey et al. (2019) recommend therapists to seek consultation or personal therapy to assess their motivations and possible consequences of converting a professional relationship into a personal one. In contemplating such a relationship, relevant factors to consider include the length of time since therapy termination, the nature and duration of the therapy process, the circumstances that existed during therapy termination, client's personal history, competence, and mental status, possibility of harm to client or others, and any therapist comments or actions that suggested a plan to begin a sexual relationship with client after termination. Koocher and Keith-Spiegel (2016) believe that sexual relationships with former clients manifest high potential for numerous risks, thus, they strongly discourage them, regardless of the lapse of time cited in the ethics codes.

NONEROTIC TOUCHING WITH CLIENTS

Nonerotic touching is a controversial boundary crossing as some believe that it can lead to sexual exploitation while others feel it can be appropriate and have significant therapeutic value. A therapist's touch can display care and compassion, be reassuring, and contribute to the healing process. In contrast, touching may only serve to fulfill therapist's own needs, therefore, therapists must carefully evaluate the appropriateness of touching clients (Koocher & Keith-Spiegel, 2016). It is not appropriate to touch some clients under any circumstances. Zur (2007) and Zur and Nordmarken (2009) profess that touch needs to be evaluated relative to client factors, the professional setting, therapist's theoretical orientation, and the quality of the therapeutic alliance. Client variables involve gender, age, class, culture, personal history with touch, presenting issue(s), diagnosis, and personality. The same type of touch may be effectively therapeutic for some clients yet harmfully inappropriate for others.

Zur and Nordmarken (2009) suggest that clinically appropriate touch can enhance client's trust and ease with therapist and strengthen the therapeutic relationship. In opposition, nonerotic touching has a negative side. Some practitioners believe that inherent dangers lie within physical contact while others reject any type of physical contact between clinician and client because it can: encourage dependency, conflict with the transference relationship, be misunderstood by client, and become sexualized. Pope and Wedding (2014) highlight additional dangers: "When discordant with clinical needs, context, competence, or consent, even the most well-intentioned nonsexual physical contact may be experienced as aggressive, frightening, intimidating, demeaning, arrogant, unwanted, insensitive, threatening, or intrusive" (p. 585). Gutheil and Brodsky (2008) maintain that the consideration of touch in therapy must be viewed with caution and clinical understanding. They profess that therapist may accept a client hug in rare cases, such as a client in extreme grief who reaches out to therapist or from client at the end of a long course of therapy, but "there are virtually no circumstances in which it is appropriate for a therapist to initiate a hug with a patient" (p. 167).

Corey et al. (2019) advise that therapist must resolve whose needs are being fulfilled by touching; if only therapist's needs and not the needs of the therapeutic context, then touch should be avoided. If touching does occur, it is recommended to be spontaneous, nonsexual, an expression of therapist's true feelings, and enacted for client's benefit. Touching is not recommended to be performed as a technique, nor if this behavior is incongruent with therapist's feelings because an insincere touch could be detected by client and diminish trust in the relationship.

Touching is unproductive if it detracts clients from experiencing their feelings, or if clients prefer not to be touched. Some clients may generalize any physical contact to their experience in past dysfunctional relationships. Therapist must consider any contact with caution because it is initially unknown how client will interpret or react to touch. Clients with abusive backgrounds may distort therapeutic physical contact as expression of dominance or a method of inflicting harm; such clients may perceive any type of touch as having sexual connotations (Gutheil & Brodsky, 2008).

Therapists need to be aware of the meaning of physical contact and their motives for touching. They also need to process client's readiness for physical closeness, client's cultural perspective on touching, client's reaction to the touching, the likely effect of touching on client, and the established trust level extant with client.

Zur and Nordmarken (2009) point out that touch in therapy is not inherently unethical and none of the professional organizations' codes of ethics classify touch as being unethical. They suggest consultation in employing touch in

complex and sensitive cases. Documenting the type and frequency of touch, and the clinical rationale for its usage constitutes sound ethical practice. Zur and Nordmarken recommend these ethical and clinical guidelines regarding nonsexual touch in therapy:

1. Only use touch when it is deemed to have a positive therapeutic effect.
2. Touch should be used based on therapist's training and competence.
3. The establishment of client safety and empowerment is recommended before using touch.
4. Evaluate client's possible perception and interpretation of touch before using touch.
5. Additional care is advised in using touch with clients who have a history of assault, neglect, rape, attachment difficulties, molestation, sexual addictions, or intimacy issues.
6. Therapists are responsible to address their personal issues regarding touch and to pursue education and consultation concerning appropriate usage of touch in therapy.
7. Therapists should not use fear of licensing boards or litigation as the rationale for avoiding touch in therapy.
8. Be sensitive to client's personal factors such as gender, culture, presenting issues, situation, history, and diagnosis.

Zur and Nordmarken advise therapists to avoid abusing the trust and power they possess in the therapeutic relationship. They declare "Power by itself does not corrupt; rather, it is the lack of personal integrity on the therapist's part that corrupts."

Corey et al. (2019) offer the following case study on touch in therapy:

Case 1 - Therapist is warm and empathic and routinely embraces his clients, whether male or female. His client has experienced a hard life, has no success in maintaining relationships with men, is almost 40-years-old, and sought therapy because she is afraid she will always be alone. Client misinterprets therapist's friendly embrace and wrongly assumes he is sending her a personal message. At the closure of one session when therapist gives his customary embrace, client holds onto him and does not let go immediately, and expresses, "This is special, and I look forward to your hugs." Therapist is startled and embarrassed and tells client she misunderstood his gesture that he hugs all his clients, and he is sorry if he misled her. She is brokenhearted and quickly leaves the office; later, she cancelled her next appointment.

Analysis - Therapist was more concerned with his predicament than the client's situation. A therapist's work is designed to address the client's difficulty first. Therapist assumed he understood client's message, and his response satisfied his emotional needs rather than client's. Therapist would have demonstrated placing his client's needs first had he encouraged client to disclose the meaning for her of his embrace. Therapist must recognize his own possible countertransference and how this may affect his interpretation of client's reaction. Clinicians are wise to assess their relationship with client and client's presenting issues before exercising "routine" practices. Corey et al. (2019) advocate, "Touching should be approached with caution and with respect for the client's boundaries."

NEW YORK STATE LAWS, RULES, REGULATIONS, and ETHICAL PRINCIPLES

Given that ethical codes of associations may be different from New York law, psychologists, LCSWs, LMSWs, LMHCs and LMFTs must comply with the rules and regulations compiled by the Board of Regents and the State Education Department, including rules of "Unprofessional Conduct," which are accessible at these websites:
https://www.op.nysed.gov/title8/rules-board-regents/part-29

www.op.nysed.gov/professions-index/mental-health-practitioners

The New York State Education Department, Office of the Professions cites the following on "Dual Relationships" on their website at: https://www.op.nysed.gov/professions/psychology/professional-practice/dual-relationships
(The content is applicable to psychologists, LCSWs, LMSWs, LMHCs, and LMFTs except for the timeframes regarding sexual relationships with clients which are previously indicated in the section entitled "New York State Rules, Regulations, and Ethical Principles").

Psychologists should be aware that the objectivity and appropriateness of professional services could be jeopardized by the existence of dual relationships. Dual relationships occur when a psychologist has more than one type of relationship with a patient or client, such as:

- A professional relationship and a prior personal relationship
- A business relationship that develops during a professional relationship
- Social or personal relationships that develop during a professional relationship
- Differing professional relationships, such as performing custody evaluations with patients or clients who are in other treatment or business relationships

Sexual relationships with patients/clients either during or within at least two years following the professional relationship may not occur.

When psychologists are involved in a mentoring, teaching or supervisory relationship with a student, the psychologist should take care to maintain appropriate boundaries so that his or her professional judgment is not jeopardized.

The relationship of psychologists who act as supervisors for persons who are gaining experience for licensure purposes is principally with the licensing agency and not with the supervisee. That is, the supervisor must attest to the licensing agency that the supervisee has completed the experience in

accordance with the regulations for licensure. This means that the supervisee should not employ the supervisor when the supervisee is gaining experience for licensure. In addition, supervisors would be wise to avoid supervising relatives and close friends.

The New York State Education Department, Office of the Professions cites the following on the subject of "Maintaining Appropriate Professional Boundaries" on their websites at:
https://www.op.nysed.gov/professions/psychology/professional-practice/dual-relationships

https://www.op.nysed.gov/professions/social-work/maintaining-appropriate-professional-boundaries

https://www.op.nysed.gov/professions/mental-health-practitioners/professional-practice/maintaining-appropriate-professional-boundaries

https://www.op.nysed.gov/professions/marriage-and-family-therapists/professional-practice/maintaining-appropriate-professional-boundaries
(The content is identical for psychologists, LMHCs and LMFTs whereas minor content differences exist for social workers).
Guideline 5: Maintaining Appropriate Professional Boundaries
It is your responsibility, not your patient's, to maintain appropriate boundaries in your professional relationship. All complaints of inappropriate behavior by licensed professionals are taken very seriously. The Regents Rules define as unprofessional conduct a licensed professional exercising undue influence on a patient in such a manner as to exploit the patient or conduct that evidences moral unfitness to practice the profession of a licensed mental health practitioner.
You should be especially vigilant regarding any conduct that could impair your objectivity and professional judgment in serving your patient, and any conduct that carries the risk and/or the appearance of exploitation or potential harm to your patient. If a current or former patient files a complaint against you, it will be your responsibility to demonstrate that you have not exploited or coerced the patient, either intentionally or unintentionally.
The practice of the mental health professions, including counseling and psychotherapy, requires interaction with patients, which may be emotional. In most cases, it is advisable to avoid hugging or other physical contact that could imply that you have a personal, rather than a professional, relationship with the patient. If a situation arises that leads you to believe that a hug or similar contact is appropriate, you should still seek the patient's consent before touching or hugging him or her to minimize the risk of misunderstanding or allegations of inappropriate contact.

You should recognize and avoid the dangers of dual relationships when relating to patients in more than one context, whether professional, social, educational, or commercial. Dual relationships can occur simultaneously or consecutively. Some of the types of situations that may lead to problems include, but are not limited to:

- accepting as a patient anyone with whom you have had a prior sexual relationship;
- forming a sexual relationship with a current or former patient;
- treating patients to whom you are related by blood or legal ties;
- bartering with patients for the provision of services;
- supervising applicants for licensure or other training when you are related by blood or legal ties, or when you are having or have previously had a sexual relationship with the trainee;
- referring patients to services in which you have a financial relationship, without disclosing that you may stand to benefit financially from their use of the service; and
- entering into financial relationships with patients other than their paying for your professional services.

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TEST - MAINTAINING APPROPRIATE PROFESSIONAL BOUNDARIES

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For True/False questions: A = True and B = False.

1. **The ethics codes advise professionals against any involvement with clients that may __________.**
   A) diminish their judgment and objectivity
   B) impair their rendering effective services
   C) culminate in harm or exploitation of clients
   D) All of the above

2. **Though bartering is not prohibited by law or ethics, most legal professionals __________.**
   A) recommend the practice on a routine basis
   B) look down on the practice
   C) recommend 50% of therapist's caseload to be remunerated as such.
   D) believe it has fewer complications than monetary payment

3. **Accepting expensive client gifts is considered __________.**
   A) always beneficial for the client
   B) always welcome
   C) potentially problematic and unethical
   D) a non-issue and not worthy of discussion

4. **In a study, therapists shared their reasons for abstaining from acting out their attraction to clients, which included __________.**
   A) the need to uphold professional values
   B) concern regarding welfare of client
   C) desire to follow personal values
   D) All of the above

5. **__________ is a serious ethical violation for therapists, and it is one of the most common allegations in malpractice suits.**
   A) Sexual misconduct
   B) Excessive fee structure
   C) Receiving gifts
   D) Self-indulgent self-disclosure

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TRUE/FALSE: A = True and B = False

6. **Dual relationships arise when professionals assume two or more roles simultaneously or sequentially with a client, or with another person who is close to the client.**
   A) True B) False

7. **Ethical concerns may result and must be considered when practitioners blend their professional relationship with a nonprofessional relationship with a client because these scenarios may blur the best interests of the client.**
   A) True B) False

8. **Dual relationships or boundary crossings increase the chance that practitioners might misuse their power to influence or exploit clients for their personal benefit and to clients' disadvantage.**
   A) True B) False

9. **Therapist self-disclosure should not be burdensome to client or make client feel the need to nurture therapist.**
   A) True B) False

10. **It is not the therapist's responsibility to have a straightforward discussion with client regarding the possible problems and risks of bartering because client is aware of potential conflicts.**
    A) True B) False

11. **The crossing of a boundary can result in a tendency to employ a number of increasingly serious boundary violations promoting progressive degradation of ethical behavior.**
    A) True B) False

12. **Issues regarding therapeutic boundaries arose in the 1960s and 1970s due to extensive lack of regard for boundaries by many mental health professionals and the subsequent client exploitation.**
    A) True B) False

13. **Practitioners are always responsible for controlling their feelings toward clients, and transferring blame to the client is never an excuse for unethical or unprofessional conduct.**
    A) True B) False

14. **Regarding receiving gifts, knowing client's motive for gift-giving is not essential in deciding acceptance or rejection of the gift**
    A) True B) False

15. **Therapists are advised to understand their reasons and motivations for sharing personal experiences or reactions in a therapy session.**
    A) True B) False

16. **Barnett asserts that the goal for rural therapists is not avoiding all multiple roles and relationships, instead, it is managing such relationships in an ethical and mindful manner.**
    A) True B) False

17. **Corey et al. (2019) acknowledge that forming friendships may not be unethical or illegal but the practice can create problems, hence, the safest policy is avoiding forming social relationships with former clients.**
    A) True B) False

18. **Therapists who have issues with setting clear boundaries in their personal life are less likely to have concerns in defining appropriate boundaries with their clientele.**
    A) True B) False

19. **Therapists are advised to monitor their feelings given sexual attraction to their clients, and to examine this issue in supervision or their own therapy if feeling frequently attracted.**
    A) True B) False

20. **It is advised for therapists to recognize their countertransference reactions and manage them to prevent sexual feelings from affecting the therapy process.**
    A) True B) False

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