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Patient–Therapist Boundary Issues: An Integrative Review of Theory and Research

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Boundary issues, which regularly arise in therapy, can present difficult dilemmas for clinicians. The purpose of this article is to help clinicians resolve these dilemmas by integrating some of the theoretical positions with empirical evidence reported in the literature on boundary issues in counseling and psychotherapy. The authors review the concept of treatment boundaries and the ethical principles that underpin them. They also review common boundary violations and provide recommendations to attenuate harm done to clients when such boundary violations occur in therapy.

It has long been recognized that boundary violations by health care professionals pose a potential for serious harm to their clients. The Hippocratic Oath, which appeared about 2,200 years ago, obliges physicians to "[keep] far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women and men" (Dorland's Medical Dictionary, 1974, p. 715). Early this century, Sigmund Freud made a number of strong statements on this issue. Perhaps most significant, he clearly distinguished the clinical phenomenon of transference from the nonclinical experience of "falling in love": "The patient's falling in love is induced by the analytic situation and is not to be ascribed to the charms of [the analyst's] person" (Freud, 1963, as cited in Pope & Bouhoutsos, 1986). Furthermore, he believed that a sexual relationship between therapist and patient was antithetical to a positive therapeutic outcome: "The love-relationship actually destroys the influence of the analytic treatment on the patient: a combination of the two would be an inconceivable thing" (Freud, 1963, as cited in Pope & Bouhoutsos, 1986). After Freud, public discussion of the issue diminished—and in some contexts was even discouraged (see Pope & Bouhoutsos, 1986, pp. 25–32)—until the 1960s when significant political and social changes in North America led to renewed interest in the topic. The issue of boundary violations in counseling and psychotherapy is now a serious matter of scientific research, legislation, and litigation.

One specific kind of violation, the sexual misconduct of mental health professionals, has received the most intense scrutiny, a scrutiny that is understandable given its potential for severe and enduring consequences. Yet, there are many other kinds of boundary issues that present troubling dilemmas to clinicians on a daily basis. Our review attempts to draw together some of the major issues in the discussion and to propose some avenues of prevention for clinicians facing dilemmas in everyday practice.

The Concept of Treatment Boundaries

One way in which treatment boundaries have been conceptualized is as a therapeutic frame which defines a set of roles for the participants in the therapeutic process. The frame has been described in several ways, including as ground rules of psychotherapy (Langs, 1982) and as unchanging basic elements that define psychotherapy and distinguish it from other kinds of social events (Spruiell, 1983). The therapeutic frame includes both the structural elements (e.g., time, place, and money) and the content (what actually transpires between therapist and client) of therapy. Although therapists are largely responsible for constructing and maintaining the therapeutic frame, it is generally accepted that patients also contribute to its development (Gutheil & Gabbard, 1993; Langs, 1982; Spruiell, 1983).

The growth of managed care in the United States as an alternative to the more traditional fee-for-service delivery systems has significantly altered this conceptualization of the therapeutic frame. In managed care settings, the therapeutic relationship is no longer a "private contractual world of the provider and consumer" (Haas & Cummings, 1991). Rather, health maintenance organizations (HMOs), in their efforts to contain costs, have expanded the therapeutic frame to include themselves. HMOs exert substantial influence over treatment decisions—such as the length of treatment, the number of sessions, and even the content of therapy—through their directives and financial incentives to clinicians. This relatively recent development in health care delivery has raised new ethical questions. Unfortunately, ethical guidelines bear only obliquely on practice within managed care settings, providing less than adequate guidance to clinicians attempting to negotiate their divided loyalties (Newman & Bricklin, 1991).

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Haas and Cummings (1991) identified several sequelae of managed care on the therapist–patient relationship that reflect the altered nature of boundaries within HMOs. First, they speculated that clients who wish to circumvent the rules after their benefits have been exhausted may evoke efforts in therapists to collude with them in "beating the system." Conversely, clients who show dependency or a sense of entitlement may alienate therapists and evoke tendencies in therapists to prematurely terminate them from therapy. Similarly, clinicians may transfer patients requiring long-term care to public facilities before all of their benefits have been used. Although similar outcomes in traditional health delivery systems are possible, the presence of a powerful, cost-conscious third party heightens the salience of these issues in client–therapist relationships within managed care settings.

Several principles underpin the concept of boundary guidelines in psychotherapy. The first of these is the principle of abstinence (Simon, 1992). According to this principle, therapists in their interactions with clients should refrain from self-seeking and personal gratification that is beyond the professional satisfaction derived from being a part of the therapeutic process. A corollary of this principle is that the only acceptable quid pro quo is the fee paid for the professional service (Epstein & Simon, 1990; Simon, 1992). A second principle underpinning boundary guidelines is the duty to neutrality (Simon, 1989, 1992). According to this principle, the client's agenda is the primary consideration in therapy. Clinicians are forbidden to meddle in clients' personal affairs that are outside the therapeutic agenda and to share unsolicited personal opinions in therapy. This is a duty that has been recognized in case law (Simon, 1989). A third principle states that clinicians must always strive to enhance a client's autonomy and independence (Simon, 1992). Proper maintenance of treatment boundaries fosters autonomy and independence in clients, whereas progressive boundary violations restrict their freedom to explore and choose.

The importance of maintaining adequate treatment boundaries becomes apparent when one considers the nature of the therapeutic process. A large body of research has consistently pointed to the quality of the therapeutic alliance as a critical factor in successful therapeutic outcome (Whiston & Sexton, 1993). Proper boundaries provide a foundation for this relationship by fostering a sense of safety and the belief that the clinician will always act in the client's best interest. This foundation permits the client to develop trust in the therapist and to openly express secret fears and desires without fearing negative consequences (Langs, 1982; Simon, 1992). Moreover, establishing clear boundaries about what is and is not acceptable within the therapeutic context sets a standard for unambiguous communication between therapist and client and decreases the possibility for misinterpretations of the therapist's messages, motives, and behaviors (Langs, 1982). Given this definition of treatment boundaries, it is clear the boundaries are regularly transgressed by even the most competent therapists, and such transgressions are not always to the detriment of the client.

One may conceptualize the diversity of boundary transgressions on a continuum ranging from those that pose little, if any, risk of harm to the client to those that put the client at risk of indelible psychological injury and, in the most extreme instances, suicide (Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983). It is useful to distinguish between *boundary crossing* and *boundary violation. Boundary crossing* is a nonpejorative term that describes departures from commonly accepted clinical practice that may or may not benefit the client. The client who brings a Christmas gift to his or her therapist has crossed a therapeutic boundary by offering something over and above the agreed-upon fee for professional services. The therapist may decide to cross the same boundary and accept the gift. The therapist's decision, however, should be based not on a desire for the gift or on a desire to avoid the discussion that would ensue from refusing the gift but on a judgment of whether the client might be more harmed than helped by a refusal. The question the clinician must ask is, "How can my client most benefit? Can he or she tolerate and learn from my refusing this offering that violates the boundaries of our relationship?" Minor boundary crossings, especially those initiated by the client, can provide grist for the therapeutic mill and be an important focus of therapeutic work in psychodynamic psychotherapies. A *boundary violation*, on the other hand, is a departure from accepted practice that places the client or the therapeutic process at serious risk (Gutheil & Gabbard, 1993; Simon, 1992). In the case of minor violations, it is often possible for the therapist to repair any damage by broaching the topic with the client and, if appropriate, apologizing to the client.

Although all competent clinicians would probably agree that setting appropriate boundaries is a clinical imperative, the wide range of theoretical orientations and techniques pose a major problem when attempting to delineate the proper boundaries of clinical practice. For example, a psychoanalytically oriented clinician may view a colleague's supportive brand of psychotherapy as indulging the patient's transference wishes and as clearly outside the acceptable limits of therapeutic practice. Consider the difference between the clinician who believes that effective psychotherapy can only occur within the four walls of the consulting room versus the therapist who accompanies patients (e.g., those with anxiety disorders) to various locales for in vivo exposure sessions. The issue of divergent belief systems among therapists is more than just a point of theoretical interest in this debate; it has serious real-life ramifications. Goisman and Gutheil (1992) recounted one instance in which such differences gave rise to acrimonious legal allegations:

> We are aware of a case currently in litigation where a number of the charges against an experienced behavior therapist flowed from the testimony of a psychoanalytically trained expert witness, who faulted the behavior therapist for assigning homework tasks to patients, hiring present and former patients for jobs in psychoeducational programs and other benign interventions, and performing a sexological examination and sensate focus instruction in a case of sexual dysfunction. From a psychoanalytic viewpoint all of these would likely constitute boundary violations of a potentially harmful sort, but from a behavioral viewpoint this is not at all the case. (p. 538)

It is important that we, as professionals, be able to distinguish those interventions that violate our theoretical position from those that put the client at risk of harm. It is the latter that our ethical principles oblige us to examine.

Maintaining Treatment Boundaries

There is wide agreement among mental health professionals that the clinician is solely responsible for ensuring that the limits of the professional relationship are properly maintained (Gutheil & Gabbard, 1992; Langs, 1982; Simon, 1992), even though both client and clinician participate in boundary breaches (Eyman & Gabbard, 1991; Gutheil, 1989; Gutheil & Gabbard, 1992). This belief is often justified by the presumed power differential in the therapeutic relationship. Advocates of this position point to several characteristics of the therapeutic relationship that place the therapist in a position of power over the client (Gabbard, 1994; Lerman & Rigby, 1990; Pope & Bouhoutsos, 1986, pp. 22–23; Simon, 1992; Smith & Douglas, 1990). First, the therapeutic relationship is characteristically a one-way relationship in which the therapist learns much about the client's most private thoughts and feelings, whereas the client learns very little about the therapist. Second, clients are presumed to be more emotionally needy than therapists and, consequently, more vulnerable to psychological injury. Under these conditions, a negligent intervention by the clinician can cause lasting injury to the emotionally exposed client. Third, when filing a complaint against therapists, patients (explicitly or implicitly) waive their right for privacy because rendering a judgment requires that the content of therapy and, hence, their personal lives, be examined in a public forum. Unlike patients, therapists' professional conduct (and not their personal lives) undergoes scrutiny in these proceedings; therefore, "an implicit threat of blackmail" is presumed to exist (Gabbard, 1994, p. 331). Finally, there is the power traditionally ascribed to healers in our society. Like the shaman in less developed societies, the modern healer is perceived as having a special power to alleviate suffering and to prolong life. Today, however, this power is derived from technical knowledge rather than from magical powers.

That a power differential exists in all therapies has not always been accepted. Some authors have suggested that the client may actually wield power over the clinician in some circumstances (Deaton, Illingworth, & Bursztajn, 1992; Slovenko, 1991). There are anecdotal reports in the literature of therapists who felt exploited by their clients (Gutheil & Gabbard, 1992). Several authors reported that patients with borderline personality disorder present a particular challenge in maintaining treatment boundaries because they are usually adept interpersonal manipulators and often attempt to draw the therapist out of the therapeutic role and into a "special" relationship (Gutheil, 1989; Simon, 1989). In a more extreme statement, Slovenko (1991) asserted that the emotionally deprived therapist is often "the innocent and vulnerable one, especially with patients who are young, attractive, and malicious" (p. 604). Unfortunately, the motives of some of these authors have been misconstrued in today's rather volatile political climate, leading some critics to suggest that their accounts are veiled attempts to "blame the victim" (see Gutheil & Gabbard, 1992).

Another argument often cited in support of the position that clinicians are responsible for maintaining treatment boundaries is the psychodynamic concept of transference. Transference is presumed to interfere with a client's ability to give informed consent to sexual relations with the therapist (Pope & Bouhoutsos, 1986, p. 23). According to this line of reasoning, attraction to the therapist arises from the client's investing the therapist with certain properties that relate to the client's unresolved conflicts. The argument that clinicians who commit boundary violations "mismanage the transference" was first used in the landmark case of *Zipkin v. Freeman* in 1968 and is now commonly advanced by plaintiffs in courts of law. Another landmark decision was *Roy v. Hartogs* (1975) in which the court was convinced by counsel's assertion that the phenomenon of transference deprives the patient of the ability to make independent and informed judgments regarding the relationship with the therapist. More broadly, this decision implies that transference compromises the patient's free will vis-à-vis the therapist (Slovenko, 1991). Gabbard (1994) reported that transference tends to persist after therapy and that posttherapy boundary crossings can compromise the working through of unresolved transference issues that occurs after formal termination of therapy.

The use of the theoretical construct of transference to back up legal arguments has raised important objections. Behavior therapists and biological psychiatrists, among others, have a particularly difficult time accepting this line of reasoning because the construct is derived from classical psychoanalysis and is not considered applicable to treatment by many of these therapists (Goisman & Gutheil, 1992; Simon, 1992). Even if transference is accepted as a legitimate argument in legal proceedings, can one correctly assume that it applies to every counseling and therapy case or that it operates in the same way over the course of treatment? It is conceivable that less intimate kinds of help, such as career and educational counseling, didactic group workshops, and short-term therapy, may not engender transference in the same way as do long-term psychodynamic therapies (Gonsiorek & Brown, 1989). However, even in situations in which transference may not be operative, it is equally conceivable that some boundary crossings may compromise other important therapeutic factors, such as clinicians' objectivity and perceived expertise. Slovenko (1991) noted that "all human relationships are tinged with transference" (p. 603) and on these grounds argued that the courts have unfairly singled out psychotherapists from all other professions such as law and medicine. Unlike other professions, though, psychologists are expected to understand those who consult with them. Because of the opportunity we, as psychologists, have to understand the process of our interactions, perhaps we have an obligation to be the most circumspect in our professional dealings. Certainly our understanding of human behavior calls us to continually examine our own behavior, regardless of whether we embrace the transference construct.

Types of Boundary Violations

Dual Relationships

Among the many types of boundary crossings, dual relationships (e.g., in which a client is also a friend or colleague) present a particularly difficult challenge. Dual relationships include situations in which a psychologist functions in a professional role concurrently or consecutively with another "definitive and intended role," professional or otherwise (Sonne, 1994). This

definition excludes inconsequential roles that arise from chance encounters. Generally, professional organizations prohibit dual relationships because of the risk of harm posed by incompatible behaviors that might arise from the multiple roles (Gottlieb, 1993).

Unfortunately, many great historical figures are poor role models for the profession (Gutheil & Gabbard, 1993). Sigmund Freud, for example, analyzed his friend, Sandor Ferenczi, and his own daughter, Anna. Melanie Klein had one patient follow her on a holiday during which she analyzed him for two hours each day on her hotel bed. D. W. Winnicott took patients into his home as part of their treatment on several occasions. Not surprisingly, Pope and Vetter (1992) reported that the problem of dual relationships was the second most troubling ethical dilemma faced by their sample of more than 1,300 members of the American Psychological Association (APA).

In their national survey of social workers, psychologists, and psychiatrists, Borys and Pope (1989) found three interesting things. First, the three professional groups did not differ in the extent to which they engaged in various kinds of dual relationships, with one exception: Psychologists tended to engage more frequently than the other groups in incidental involvements (e.g., accepting a gift of more than $50 or accepting an invitation to a client's special occasion). Ironically, although only the APA's code of ethics explicitly discourages dual relationships, psychiatrists tended to view such involvement as less ethical than the other groups. Second, results consistently showed that psychodynamically oriented practitioners from all three groups engaged in dual relationships less frequently and viewed them as less ethical than clinicians of other theoretical persuasions. Third, gender discrepancies that characterize sexual relationships between therapists and clients (see section on Therapist–Client Sexual Contact) also apply to dual relationships across all groups, with male clinicians viewing this behavior as more ethical and engaging in it more frequently than their female colleagues.

That dual relationships are inevitable in certain circumstances adds to the complexity of the issue. In small towns and rural communities, dual relationships are often unavoidable; denying help to a potential client because of a preexisting relationship could mean that the person gets no help at all. Moreover, in rural settings where mental health professionals might be regarded with suspicion, heightening one's visibility by way of involvement in community activities may defuse the suspicion and make the clinician appear more approachable (Gates & Speare, 1990). People's political affiliations, ethnic backgrounds, or sexual orientations can lead to dual relationships, as clients often seek therapists with similar values and consequently search within these communities for professional help (Lerman & Porter, 1990). Finally, in academic and professional circles, it is not uncommon that therapists in different roles, such as supervisor, instructor, or colleague, will encounter current or former clients.

Unfortunately, current ethical codes, including the newest APA guidelines (1992), do not offer much assistance to clinicians trying to resolve the dilemmas that may arise from dual relationships (Gottlieb, 1993; Lerman & Porter, 1990; Pope & Vetter, 1992; Sonne, 1994). They do not adequately address the inherent complexity of dual relationships; they fail to specify the conditions under which an extratherapeutic relationship may be harmful, benign, or actually beneficial. Sonne (1994), although recognizing the APA's attempt to account for the complexity of this issue, criticized the APA ethics code (1992) for its "pervasive ambiguity." Noting the breadth and generality of the proscription against multiple relationships in the ethics code, she demonstrated how the code could actually be used to justify unethical practices. Ryder and Hepworth (1990) criticized the latest Code of Ethical Principles for Marriage and Family Therapists (American Association for Marriage and Family Therapy, 1988) for its restrictive stance toward dual relationships. They argued that "differences in status and power, not specifically dual relationships, facilitate exploitation" (p. 130). They further argued that such rules run counter to the widely accepted notion among mental health providers that human relationships are tremendously complex and rife with ambiguity. Rules alone do not negate this reality, nor do they address all of the issues it raises. Dual relationships are ubiquitous and will remain a hazard of the mental health professions (Gottlieb, 1993; Phillips & Lee, 1986).

In an effort to redress the shortcomings of the APA ethics code, several authors have proposed guidelines to help psychologists identify and avoid unethical dual relationships. Sonne (1994) proposed that a dual relationship constitutes unethical conduct when a secondary relationship adversely affects the dynamics of the professional relationship. These dynamics include relationship-related and role-related responsibilities and expectations, the client's emotional involvement with the therapist, and the power imbalance. Gottlieb's (1993) decision-making model instructs psychologists to make judgments about the original professional relationship (from the perspective of the consumer) on the basis of three dimensions: power, duration, and clarity of termination. According to the model, as estimated values on these dimensions increase, so does the consumer's risk of harm posed by an additional relationship. Unfortunately, the power dimension as described by Gottlieb is too general to produce reliable and valid judgments and needs further explication. Its utility might be enhanced by enumerating the specific elements that potentially contribute to a power imbalance between the psychologist and the consumer. A partial list might include differences on demographic variables such as age, education, gender, socioeconomic status, type and severity of psychological disturbance in the client, and type of psychological service rendered.

Physical Contact (Nonerotic)

Like the issue of dual relationships, the issue of physical contact (exclusive of overtly sexual contact) with clients in therapy is not easily resolved. On one side, a gentle, reassuring touch or hug can be the most appropriate response at certain times or with certain clients (Holub & Lee, 1990; Simon, 1992). On the other hand, clinicians practicing such behavior run the risk of having it interpreted as a sexual advance, leading to undesired consequences for both the clinician and the client (see Gutheil, 1989, pp. 600–601, for a description of such a case). There are also cultural factors to be considered. For example, in Montreal where the dominant culture is French-Canadian, kissing on both cheeks is a widely practiced greeting among friends and

even casual acquaintances. When it occurs between a therapist and client (as it sometimes does on special occasions), it does not carry the erotically charged meaning it might elsewhere in North America.

In the early psychoanalytic period, physical contact was prohibited because it supposedly had a negative impact on the processes of transference and countertransference. Historically, the issues have been clearer in theory than in practice. Freud was known to stroke a patient's head or neck, although he also cautioned Ferenczi against such behavior. Later, within the "human potential movement," touching became an accepted practice used to improve the therapeutic alliance and to effect change. Interestingly, these orientation-specific attitudes have persisted; Holroyd and Brodsky (1977) reported that 30% of humanistic therapists, but only 6% of psychodynamic therapists, believed that touching could be beneficial to clients. Although empirical research has shown that physical contact is critical to human development, research investigating the effects of touching on therapeutic outcome has not yet produced conclusive results (see Holub & Lee, 1990, for a review).

The incidence of three kinds of physical contact between therapists and clients was reported in Pope, Tabachnick, and Keith-Spiegel (1987). Kissing a client was deemed the least acceptable (85% said that it was unquestionably not ethical or that it was ethical only under rare circumstances) and was practiced with the lowest frequency (71% never practiced it, and 24% rarely practiced it). Hugging was deemed unquestionably ethical or ethical under many circumstances by 44% of respondents, yet was practiced much less frequently (only 12% hugged clients fairly often or very often). Finally, handshakes were the most widely accepted (94% considered it unquestionably ethical or ethical under many circumstances) and most widely practiced form of physical contact with clients (76% practiced it fairly often or very often). Stake and Oliver (1991) used factor analysis to distinguish three kinds of behavior: Overt Sexual Behavior, Touching Behavior, and Suggestive Behavior. Touching Behavior (touching shoulders, arm, and hand; touching leg or knee; hugging; touching hair, face, or neck; holding hands; holding client on lap) was rated overall as seldom constituting misconduct. Kissing loaded highest on Overt Sexual Behavior. Overall, participants rated behaviors in this category as always or almost always indicative of sexual misconduct.

There is a very fine, sometimes indistinguishable, line between nonerotic and erotic physical contact. Holroyd and Brodsky (1980) investigated touching and sexual activity in therapy and found no difference in the incidence of therapist–client sexual intercourse among clinicians who differed in the frequency with which they touched their clients. However, their data revealed that offending therapists, in contrast to nonoffending therapists, tended to advocate and engage in nonerotic touching with opposite-sex clients more often than with same-sex clients.

Self-Disclosure

The issue of therapist self-disclosure has received considerable attention in the literature. Freud espoused a rigid view on therapist self-disclosure, instructing the analyst to remain "opaque to his patients, like a mirror and show them nothing but what is shown to him" (as cited in Lane & Hull, 1990, p. 33), an instruction that he frequently contradicted in practice. Disagreeing with Freud's theory on the genesis of neurosis, Ferenczi experimented with several techniques designed to "unmask his [Ferenczi's] professional hypocrisy" through sincerity, authenticity, and truthfulness. In its most extreme form, Ferenczi's technique included mutual analysis in which the regular analytic session was followed by a second session in which the patient analyzed him (Lane & Hull, 1990). Likely, this would not be considered acceptable practice by the current ethical standards.

In the context of the rising number of sexual misconduct cases, self-disclosure has become an ethical and legal concern to psychotherapists. Case analyses have shown that sexual intercourse with clients does not occur in isolation. Typically, there is a gradual erosion of treatment boundaries before sexual activity is initiated (Simon, 1989). Inappropriate therapist self-disclosure, more than any other kind of boundary violation, most frequently precedes therapist–client sex (Simon, 1991).

In certain circumstances, however, self-disclosure by the therapist can be a powerful intervention, and many contemporary schools of psychotherapy encourage its practice (see Stricker & Fisher, 1990, for a comprehensive review). The hallmark of appropriate self-disclosure is that it is done for the client's benefit within the context of the therapeutic process. Used as a tool to instruct or illustrate, the therapist's disclosure of some past event or problem can help the client overcome barriers to therapeutic progress (Dryden, 1990; Lane & Hull, 1990). Informing the client about personal conditions that might cause interruptions, such as illness or pregnancy, may also be necessary (Lane & Hull, 1990; Simon, 1991). Disclosures by the clinician that are generally not considered suitable include details of current problems or stressors, personal fantasies or dreams, and social, sexual, or financial circumstances (Gutheil & Gabbard, 1993; Simon, 1991).

These distinctions, which seem clear-cut on paper, can become murky in practice. Consider the case of a young graduate student in therapy for 18 months who becomes pregnant by her new boyfriend. She comes to her session trying to resolve the question of whether to have an abortion, which she considers the rational choice given her life circumstances, or to keep the baby, which she wants. Her therapist, a married woman in her early 40s who recently miscarried after trying to conceive for many years, is aware of being too emotionally invested in the decision. In the course of the session, the client says to the therapist, "I feel as if you want me to have this baby." Does the therapist disclose the fact that her professional objectivity has been compromised? Would disclosure help the client by allowing her to weigh the therapist's bias into her decision or would it hinder her by adding another consideration to an already complex problem? Judging what is of benefit to the client is an ideal that can be very difficult to practice.

Therapist–Client Sexual Contact

Sexual intimacy between therapist and client is arguably the most disruptive and potentially damaging boundary violation that can occur in therapy. Because of the gravity of its potential consequences, therapist–client intimacies are the target of a

rapidly increasing number of legal suits and the subject of an expanding literature.

Although therapist–client sexual contact has long been recognized as contrary to the client's best interest, only in recent years has it been explicitly proscribed by organizations representing mental health practitioners (the American Psychiatric Association in 1973, the APA in 1979, and the National Association of Social Workers in 1980). In contrast to the solidarity shown by these organizations on this issue, there remains disagreement about whether a sexual relationship initiated after the termination of therapy can ever be justified. This disagreement is reflected in the contrast between APA's recent decision to limit the ban on sexual relationships with former clients to 2 years after termination of therapy versus the American Psychiatric Association's absolute ban on sexual relationships with former patients. Gabbard (1994) reviewed arguments for and against banning sexual relationships in light of APA's current policy and concluded that its "decision to declare posttermination sex as ethical appears to be premature" (p. 334). The most compelling of his arguments was his assertion that advocates of posttermination sex should bear the burden of proving the harmlessness of such behavior because the accumulated evidence to date (although relatively weak by rigorous scientific standards) at the very least raises serious concerns about potentially harmful effects of posttermination sex on clients.

Studies that have reported on the number of therapists who have had intercourse with at least one client have yielded estimates in the range of 5% to 10% (Pope, Keith-Spiegel, & Tabachnick, 1986) and 1% to 12% (Williams, 1992). Such estimates may be conservative, and the real number may be as high as 25% (Simon, 1989) because there are compelling reasons for offending clinicians to withhold information or make false-negative claims. The accuracy of these estimates may never improve. Current ethical standards obviously preclude an experimental investigation with random assignment of participants to sexual and nonsexual treatment conditions (although it has been suggested; see Riskin, 1979). The use of surveys of self-selected volunteers—the method normally used to investigate this problem—has considerable flaws (see Pope, 1990a, 1990b, 1990c; Williams, 1990, 1992) that have led some critics to reject the data and the conclusions they have generated.

A growing body of literature has documented the impact of therapist–client sexual involvement on clients. Masters and Johnson (1975, as cited in Pope, 1990c) were among the first researchers to document its "tragic consequences" for the patient, and they subsequently argued that therapists involved in such transgressions should be charged with rape. Pope and Bouhoutsos (1986) described the "therapist–patient sex syndrome," which is identified in client victims by the following: (a) ambivalence, (b) guilt, (c) feelings of isolation, (d) emptiness, (e) cognitive dysfunction, (f) identity disturbances, (g) inability to trust, (h) sexual confusion, (i) mood lability, (j) suppressed rage, and (k) increased suicide risk.

Bouhoutsos et al. (1983) had psychologists describe the effects of therapist–client sex on clients (current and former) who had reported sexual involvement with therapists. Results revealed that 90% of clients were adversely affected by such involvement, with effects ranging from negative feelings about the experience to suicide. Ten percent of respondents reported that their clients either did not suffer adverse effects or benefited from the experience. Feldman-Summers and Jones (1984) found evidence of greater mistrust and anger toward men and therapists in women who had had sexual contact with their male therapists than in women who did not. Their informants also reported a greater number of psychological and psychosomatic symptoms following the termination of therapy.

A number of authors have tried to shed light on therapist variables that contribute to the degeneration of the therapeutic relationship into a sexual relationship. Systematic research on this topic is scant, and profiles of offending therapists in the literature are based mostly on clinical impressions mixed with very limited empirical data. To date, the most common profile to emerge is that of a middle-aged male therapist who is professionally isolated and is currently undergoing some personal distress or midlife crisis, often including marital problems. This so-called "lovesick" therapist typically begins his descent down the slippery slope by sharing his own problems and exposing his own vulnerability to a younger female client (Gabbard, 1991; Olarte, 1991). (For a review of other therapist factors and psychodynamics implicated in this and other kinds of boundary violations, see Gabbard, 1991; Pope, 1994; Schoener and Gonsiorek, 1990; and Twemlow and Gabbard, 1989.)

Recommendations and Conclusion

All clients enter therapy with a range of needs that reflect their varying degrees of psychological adjustment, and they may look to their therapist to satisfy some of these needs. Gratifying any of these needs, adaptive or otherwise, may entail some form of boundary crossing (e.g., giving the client a hug, making a self-disclosure, or writing a letter on the client's behalf); such boundary crossing poses a difficult clinical dilemma. Gutheil and Gabbard's (1993) distinction between *libidinal demands* and *growth needs,* although couched in psychodynamic terminology, articulates an important principle. Clinicians should consider the nature of their clients' needs and make their decision on the basis of what would benefit the client. In the face of uncertainty, therapists are advised to err on the side of caution and abstain from crossing a boundary when there is a potential that their behavior, however well-intentioned, could be construed as misconduct by clients or peers.

To aid mental health professionals in following this principle, two general recommendations for preventing boundary violations have been suggested. First, instructors and clinical supervisors must educate clinical trainees in the complexities of boundary issues in psychotherapy (Strasburger, Jorgenson, & Sutherland, 1992). The more informed that therapists are about such issues, the better prepared they will be to deal with them when they arise. Second, clinicians should be encouraged to seek consultation, supervision, or even personal therapy when maintaining proper treatment boundaries becomes too difficult (Pope, 1987). Consultation, a discussion with one or more colleagues of relatively equal status, is an appropriate choice for therapists facing difficult decisions in cases with complex boundary issues. Although consultation may be adequate for experienced clinicians, supervision designed to "facilitate the development of therapeutic competence" (Russell, Crimmings, & Lent, 1984, p. 626) may be warranted for inexperienced ther-

apists who are not yet ready to assume full responsibility for particularly challenging cases. Therapy should be considered when a clinician's personal issues tend to obscure boundaries in therapy. Such measures give evidence of conscientiousness and professionalism. None should be considered a sign of the therapist's failure to effectively manage the therapy.

There are also steps that clinicians can take to mitigate some of the potentially negative effects of boundary crossings (Gutheil & Gabbard, 1993). First, any therapist behavior that might be construed as a boundary violation should be justified by sound clinical reasoning. Second, in the current litigious climate, clinicians must ensure that boundary crossings are well documented. The documentation process is both a protection for the conscientious clinician and a further opportunity to examine the event itself. Finally, boundary crossings present opportunities to examine, discuss, and understand the counseling process. Consider the case of a clinician who agrees to a client's request for a reassuring hug at the end of a tumultuous session. However, the therapist raises the incident in the next session and suggests it might be an example of a previously identified tendency to sexualize intimate relationships. This then leads to an admission by the client of his or her sexual interest in the therapist, which had been denied because of fear of abandonment. As this example illustrates, clinicians who resist the temptation to sidestep a mistake can use these events to advance the therapy.

In summary, boundary issues regularly pose complex challenges to clinicians. The effects of crossing commonly recognized boundaries range from significant therapeutic progress to serious, indelible harm. The issues are further complicated by the wide range of individual variation that exists in a field where what is normal practice for one clinician may be considered a boundary violation by another. Although setting appropriate boundaries is a professional imperative, flexibility in their maintenance is equally important. Clinicians should avoid setting simplistic standards that may create barriers to therapeutic progress. In the final analysis, ethical practice is governed less by proscriptions than by sound clinical judgment bearing on the therapeutic interventions that will advance the client's welfare. Given the individual differences among clients, fine adjustments are required in every case.

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