BOUNDARIES AND DUAL RELATIONSHIPS

Boundary Crossings and the Standard of Care

The standard of care is defined as qualities and conditions that prevail or should prevail in a particular mental health service and that a reasonable and prudent practitioner follows. The standard is based on community and professional standards, as well as on state laws, case law, licensing boards' regulations, a consensus of professionals, ethics codes of professional associations and a consensus in the community. The standard of care is not an objective yardstick to be found in any textbook. It is closely tied to a theoretical orientation. The examples of boundary crossings mentioned [below]... clearly fall within the standard of care of behavioral, humanistic, family, and other non-analytic therapies. Regretfully, boards, courts and ethics committees too often confuse the standard of care with the analytic standards or with risk management guidelines (William, 1997). This confusion has caused tremendous injustice and immense suffering to therapists due to many boards' and courts' experts who
routinely and mistakenly apply an analytic criterion and pronounce clinically appropriate boundary crossings and dual relationships, such as those mentioned above, to be below the standard of care. (Zur, 2004)

**Boundary Crossing and Boundary Violations**

Traditionally in psychotherapy, the therapeutic relationship has been defined as a session that occurs in the therapist's consultation room (or in a psych hospital).

Boundary crossing refers to any contact with a client, that while not a violation of the boundary, is nonetheless outside the parameters set by traditional definitions of the therapeutic relationship.

Boundary crossings, by their very nature, are not a violation of laws, ethics, and the standards set by organizations like the American Psychological Association—provided that they are acceptable by the client, do not harm the client, and serve a therapeutic purpose. These have a "clear clinical rationale and has the client's welfare at heart. . . I am concerned that rigid implementation of such boundaries decreases therapeutic effectiveness." (Zur, 2010)
The therapist must be very conscious of the dynamics in the relationship, their own issues, and what they desire to accomplish. I think beginning therapists, especially have to be very careful here. Like any complex occupation, like being a surgeon or a trial attorney, there is a lot to learn and one cannot be naive about what is going on in the session on a lot of different levels.

**Walking With A Client**

**Self-Disclosure**

**Home Visits**

**Accepting Gifts**

A therapist has to be sensitive to the client's issues, personality, culture, motive, and the implications, and meaning of the gift to their client.

**BOUNDARIES VIOLATIONS**

The bottom line for all mental health care professions: Strive to do no harm.
Basically, any boundary violation involves the therapist putting themselves first.

**Obvious Boundary Violations**

Sexual contact  
Borrowing money  
Using one's status as a celebrity's or an important person's therapist  
Using a client to publically endorse you as a therapist  
Using information gained in the confidence of the therapy session to make an investment.

**DUAL RELATIONSHIPS**

Dual relationships are subtypes of boundary crossing. Psychologists practicing in rural and small communities encounter numerous unavoidable dual relationships in the course of their daily lives. The person who bags groceries in the supermarket, pumps gas, works in a dentist's office or chaperones children on school field trips may often also be the therapist's client. Relationships in such small communities can get even more complex when people choose their therapists because they know them and not
because they saw their ad in the Yellow Pages. A therapist's fellow congregation member, teammate in a local sports league or car dealer may all choose their psychologist because they have come to know him or her personally and they share values, attitudes, morals and or spiritual values. Like many other boundary crossings, such unavoidable dual relationships are not limited to rural or small communities; they are the norm within numerous small populations in larger metropolitan areas, e.g., gay/lesbian, handicapped, various minorities, religious congregations, and other such distinct small societies. In fact, duality, mutual dependence and prior knowledge of each other are prerequisites for the development of trust and respect in these communities. Non-sexual, non-exploitative dual relationships and familiarity between therapists and clients are not only normal but, in fact, increase trust. This enhances the therapeutic alliance, which is recognized as the best indicator of therapeutic results (Lambert, 1991; Norcross & Goldfried, 1992). Another excellent example is the military where, whether on a ship or in an isolated and remote base on foreign soil, dual relationships
are not only unavoidable, but, in fact, mandatory.

While dual relationships may be sometimes unavoidable, psychologists must nevertheless pay attention to the harm that can arise from them, especially where there is a conflict of interest. (Zur, 2015)