

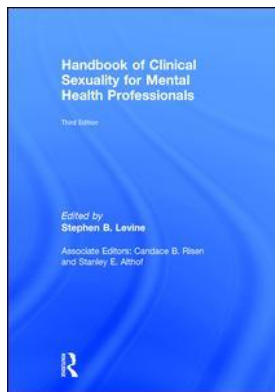
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3

BOUNDARY CROSSINGS IN CLINICAL PRACTICE

Candace B. Risen, LISW-S

I Am a Boundary Crosser

I became acutely aware of boundary issues in therapy early in my career because of my work in the sexual dysfunction clinic at University Hospitals of Cleveland. There, sexual feelings and behaviors were the main topic and the predominant force in the room. I could not ignore the subject. As time went on, I began to see professionals who had been sexual with their patients, clients, employees, parishioners, or others with whom they had related from a position of trust and authority. I spent countless hours attempting to understand how and why they came to do what they did. I came to appreciate sexual exploitation of a patient as a boundary violation that occurred only after a long series of other less egregious boundary crossings, sexual and nonsexual, that were never acknowledged or addressed. Some examples were seeing a patient for longer periods or after hours, not charging for sessions, engaging in excessive disclosure, exploring intimate details with no apparent relevance, commenting on the patient's attractiveness, accepting personal comments without exploration, hugging, and having contact outside the office. I eventually realized that these events were often in response to intense feelings, on either side, which were acted on without awareness, acknowledgment, or scrutiny.

These experiences forced me to confront the knowledge that, in my years of practice, I too had crossed boundaries without recognizing it as such or understanding the implications of what I was doing. I didn't necessarily think that these occurrences were all bad. In fact, I often felt that the crossing of a particular boundary was therapeutically indicated and perhaps even essential to fostering my relationship with the patient. But when I was in doubt, I rarely sought advice from a colleague or supervisor because of embarrassment, fear of sounding stupid or naïve, or reluctance to reveal my private feelings. However, I was lucky to be working in a setting that placed great emphasis on individual and group supervision. During our twice-weekly case conferences, patients' and therapists' feelings and behaviors were frequently brought up. Discussing the intricacies of managing intense erotic, romantic, or hostile feelings was encouraged, without fear of reprisal. I discovered that articulating *why* something seemed wrong was difficult, especially when it was suggested that I eliminate *wrong*, *bad*, and *inappropriate* from my vocabulary. It seemed that all of us leaned on the concept of something being "inappropriate" in our training, but I came to see that word as fostering shame without increasing understanding.

I was challenged to defend responses as therapeutic or anti-therapeutic and learned to argue both sides before drawing a conclusion. This reinforced the idea that, with a few exceptions, the way to proceed was not an absolute. My strategy for this chapter is to repeatedly illustrate this process.

What Is a Boundary?

Intense nonsexual and sexual feelings arise in all therapies, not just those focused on sexual concerns. And yet, in most settings, they are rarely directly discussed. The rules for the conduct of therapy, what I am calling boundaries, are often addressed only as a set of policies and procedures. What a therapist can and cannot do is shaped by law, the ethical standards of one's profession, agency policies and procedures, and local custom. I hope to convince you, however, that ultimately decision making within the privacy of therapy must be a reflection of our own good judgment.

A boundary is a line drawn between two spaces. It may be associated with safety; for example, a child may not cross the street alone, and the sidewalk is his boundary. It may be associated with ownership; for example, the property up to this boundary is mine, and beyond the line is yours. Or it may be associated with limit setting, a set of rules designed to foster socially acceptable behavior.

The unseen supportive structures of therapy, that is, its frame, are constructed with a set of boundaries. Two or more people come together in a therapy to achieve a negotiated goal to enhance the welfare of the patient(s). This frame has been characterized in various illuminating ways: an unbalanced power relationship (Hoffman, 1981), a trust-based relationship (Plaut, 2010), or a one-sided intimacy (Levine, 1998). We professionals hold power over our patients. "The power we have is the power they give to us; it is not necessarily power that we assume on our own. We are very likely to have influences on our clients far beyond our intentions or awareness" (Plaut, 2010, p. 24).

When we examine the main frame of therapy more closely, other structured edges become apparent. These define what is acceptable behavior in the clinical setting (Gutheil & Gabbard, 1993). These edges include expectations for where, when, and why therapy takes place; what may or may not go on while it is occurring; and how the therapeutic goals are to be accomplished. Each of these structured components protects the welfare of the patient and enables the work to proceed. There are further seemingly minor substructures of the frame: how we decorate our office, what we wear, what times of day or days of the week we see patients, whether we contact patients through emails, telephone chats, or text messages. The patients can feel our internalized boundaries by what we choose to talk about. Do we chat about sports, or do we readily focus on the client's conflicts? Do we share personal information? If so, when and for what purpose? Perhaps, without realizing it as such, the frame of our work, our unique interpretation of boundaries, reflects our professional ethics and our personal values. And, without realizing it, we also frequently cross some of these conventional boundaries.

Boundary Crossings Versus Boundary Violations

A boundary crossing occurs when the therapist or the patient says or does something that falls outside the structure of the prototypic therapeutic relationship. The therapist shares something about her personal life, or accepts a gift, or loses his temper. The patient reaches out to hug the therapist, invites the therapist to a celebration, or calls the therapist at home. Boundary crossings occur—sometimes purposefully, sometimes inadvertently, and sometimes out of a confusing loss of control of the situation.

Boundary violations are crossings that are not well thought out, gratify a patient's immediate need without consideration of long-term consequences, gratify a therapist's need at the expense of the patient, harm the patient, or risk harming future work. A boundary crossing with one patient might be a boundary violation with another, for example, hugging an elderly depressed person versus hugging a recognized survivor of sexual abuse.

The Concept of the Slippery Slope

It became apparent to me over time that most of the professionals who had committed major sexual infractions described increasingly blurred boundaries over a long period of time. Gabbard in 1989

described this as the “slippery slope,” a process by which the crossing of small and seemingly harmless boundaries, without obvious negative consequences, could result in making it easier to indulge in increasingly significant and harmful boundary violations. Subsequent research supported the idea that almost all harmful boundary violations were preceded by minor boundary crossings (Zur, 2007). Several authors took this further and asserted that these mini-boundary crossings (self-disclosure, gifts, hugs, etc.) *inevitably* led to boundary violations and were therefore to be avoided at all costs. This created controversy between the idea that therapy should be characterized by a rigid rule-bound process and the idea that timely boundary crossings could have high clinical utility and a positive effect on the therapeutic alliance and outcome (Zur, 2007). Most clinicians take the latter position and believe that a positive therapeutic alliance is a key factor in predicting a successful outcome. Maintaining a rigid and rule-bound stance is often viewed as coldly and uncaringly anti-therapeutic.

Whether a particular boundary crossing is helpful or harmful may vary by patient, therapist, theoretical orientation, setting, and, most important, whether or not its significance is ever acknowledged and discussed. This relative position has one vital exception, however. No therapy should include the possibility of patient–therapist sex. Sexual contact changes the goal and process of therapy and risks profoundly harming the patient and the therapist in the long run.

What Is the Role of the Therapist?

A therapist’s role is to initiate and orchestrate a series of verbal interchanges with the goal of enhancing agreed-upon growth needs. The therapist and patient roles are not equally balanced. The therapist is there to be helpful to the patient. The patient is under no obligation to be helpful to the therapist. The therapist’s role is to question, probe, and challenge the psyche of the patient in an effort to interpret, clarify, and affirm the patient’s needs and wishes. Inherent in the role is the belief that such objective and helpful intervention is possible only if the therapist’s private needs and wishes are not gratified. This has been known as the rule of abstinence—the therapist is entitled to a fee and the gratification that derives from the sincere attempt to be helpful, but nothing more!

The goal of therapy is to help the patient live better in the outside world. The therapeutic relationship is made up of bits and pieces of the client’s past relationships, often referred to as transference, mixed in with the real-time interchange between the therapist and patient. It is the therapist’s first-hand experience of how the patient relates in everyday life. It is *not* meant to be a substitute for real life. Therapists cannot and should not try to be the substitute good parent, the better partner or friend, or the answer to the patient’s prayers, although we sometimes wish we could. While patients may long for this and pressure their therapist to take on this role, yielding to their wishes ultimately leads to difficulties. The better a therapist is at being this substitute parent, partner, or friend, the less reason the patient has to make the necessary changes in the outside world in order to meet those needs. Unfortunately, however, it is often hard to delineate between a patient’s legitimate needs for warmth, understanding, and affirmation and the person’s irrational needs for the therapist to become a parent, partner, or best friend.

A female patient asks her female therapist to accompany her when she appears in court for a divorce hearing. Her husband was physically abusive, and she is afraid to face him in court alone. She has no friends whom she can ask to do this. Should the therapist go?

Pro:

The therapeutic goal was to foster enough strength and self-esteem to push forward with the divorce. This day in court is the culmination of the patient’s hard work in therapy.

The patient truly has no one else, but she is moving forward with a new life and is determined to develop healthy relationships in the future.

The therapist has reassured the patient on numerous occasions that she is not alone, that the therapist is there with her as she confronts her fears. This is a concrete demonstration of that message.

Not going may leave the patient feeling abandoned and/or betrayed without the skills to work through these feelings and maintain the therapeutic alliance.

The therapeutic alliance will be strengthened by this concrete demonstration of support and lead to further growth.

Con:

The therapist sets a precedent for being available outside of the office setting, running the risk of increasing the patient's dependency and making it less critical that she reach out to others.

The patient may actually regress in the company of her therapist, that is, be less motivated to overcome her fears and assert her wishes.

The therapist's choice to go is motivated by her excessive need to keep the patient dependent on her in order to feel important.

If the therapist charges for this, the patient may feel shame and resentment for having to "rent a friend." If the therapist does not charge for this, the patient may see this as an act of "friendship," leading to future confusion.

Alternatively, the patient may feel indebted to the therapist and unable to express negative feelings in the future.

The therapist may resent the increased demands on his or her time and manifest this in some form of negative counter-transference response.

You may feel strongly about one position or the other, but I think either can be defended, depending on the particular patient, the nature of the therapeutic relationship, and the unique circumstances. Most important, a frank discussion of both sides of the matter with the patient, before and after the event, is critical. Even if the therapist or patient retrospectively concludes that the decision made was a mistake, that discussion can be a positive and meaningful part of the therapeutic process.

Does the Patient Role Also Have Boundaries?

Yes, although patients have much more latitude. In general, they are expected to sit in a chair, engage in purposeful discussion to the best of their ability, call if they have to cancel an appointment, pay their bill, and behave in a manner that does not jeopardize the relationship. This last obligation is tricky because we often tell patients they can say anything and we encourage them to be open and honest without fear of reprisal. At the same time we expect them to express what they are feeling in a manner that is not destructive and to be willing to process what they are expressing. But what if a patient continues to be verbally abusive and will not participate in a discussion of the meaning of his anger? What if a patient continues to express her longing for an intimate connection with the therapist in a provocative manner and is unwilling to examine the nature and motives of her longings? How long does the therapist allow the unfiltered expression of feelings before stepping in and containing it? The therapist must balance allowing enough expression of feelings that the patient feels heard while at the same time attempting to examine, understand, and explain the true meaning of the feelings. It is important during these times for the therapist to be in control of the process and to be able to explain to the patient why this cannot continue.

I can see how angry you are with me. I am trying to understand why you feel as you do. But continuing to yell and swear at me makes it difficult for me to do that. I want to sort this out

together with you and help us both through it. Can you stop for a minute and allow that to happen?

I hear that you wish you could have a different sort of relationship with me and that you feel rejected when I don't respond in the way you wish I would. Can you consider that there might be a different way to understand what you are feeling? I would like to explore that with you.

Patients have greater or lesser ability to respond to such interventions, and there are times when a therapist has no choice but to stand firm on the boundary even if it means ending the discussion or terminating the session. But even having to terminate a session can be done in a helpful manner rather than in anger or anxiety.

Let's end this today and try to look at it again at another time. Perhaps we will be able to discuss it next time in a way that feels more helpful.

Summary

The role definitions for both therapist and patient form the overall boundary or frame for the work of therapy. Therapy is purposeful. Its inherent structure is more like parent and child than friend to friend because its emphasis is on the needs of one. In addition, it exists in relative isolation from the personal worlds of either party. Most often the therapist and patient did not know each other before entering into the therapy and do not have much contact with each other outside the therapy. Boundaries exist to enable the patient to obtain the maximum benefit from therapy, however great or modest this may be from patient to patient.

The Dangers of Dual Relationships

The term *dual relationship* in psychotherapy refers to any situation in which multiple roles exist between a therapist and a client (Pope & Vasquez, 2001; Zur, 2007). Dual relationships occur when either (1) friends, family members, colleagues, members of a group, and so on agree to enter into a therapeutic relationship; (2) therapist and client enter into a concurrent other relationship such as employer–employee, friend, or member of a group; or (3) therapist and former client subsequently form another type of relationship, that of friends.

Therapists often avoid taking on a client whom they already know in another familiar context, believing that they don't have the objectivity and professional distance to do their best work. Prospective clients often intuit this as well, asking their friend or family member for a referral to another therapist rather than asking to be seen. But this is not always the case. There are situations in which there is only one source of therapy and one has no choice but to seek help from a well-known and often seen member of the community. Examples of this are in rural communities where there may be only one practicing therapist or in close-knit ethnic or religious communities where members will seek out help only from one of their own. There are also circumstances involving substance or sexual abuse where patients may only feel comfortable speaking with someone whom they already know to be a fellow sufferer. In all these cases, the dual relationship will work best if both parties are mindful of and can discuss the potential conflicts that may arise.

Most therapists and patients avoid situations that will place them into another type of relationship. For example, a therapist would purposefully not hire his patient as a landscaper even if that patient was the obvious or optimal choice otherwise. A therapist and patient, both avid cyclists, might decide together that they will join two different cycling groups, at least while engaged

in the therapy. Why? Because being in a dual relationship puts a strain on the therapeutic process. Both patient and therapist are confronted with conflictual feelings that can undermine the therapy.

Therapist 1:

What if my patient does a lousy job on my lawn? How will I be able to tell him?
My patient will know where I live. He may run into my husband or children. He will see all sorts of details of my private life. That makes me uncomfortable.

Patient:

What if my therapist is disappointed with my lawn service? I'll be extra anxious about delivering extraordinary care.
I resent that I pay her XXX dollars for every therapy hour. She pays me X dollars for my lawn care. I feel inferior and it makes me angry, but I can't say that to her.

Therapist 2:

If we are members of the same club, my patient will see that I am a better/worse cyclist. I'll be anxious about forging ahead/keeping up.
I won't be able to talk as freely with my cycling buddies if my patient is around.
Will my patient feel rejected if I want to ride with others?
The group goes out for burgers and beer after the ride. I'll resent it if my patient joins us.

Patient:

I'm a better cyclist than my therapist by far. It makes him look weak, and I don't like seeing him that way.
My therapist is a much better rider. I already feel inferior, and this makes it worse. He must see me as weak and pathetic.
I feel as if we have a shameful secret when we are cycling in the group together. No one knows I am his patient, and I don't want them to. I just want to ride my bike.

Sometimes entering into another type of relationship cannot be avoided without great cost. An example of this is in academic settings where professional worlds often overlap and situations arise that pose a conflict. Mental health trainees or young clinicians often seek therapy from senior clinicians they come in contact with, need a course taught only by their therapist, or seek employment where their therapist works. In situations such as these, it is imperative that both patient and therapist maintain an active dialogue about the thoughts and feelings that potentially accompany the dual relationship.

Nonsexual relationships between therapist and patient that occur after termination may be more or less problematic depending on such factors as the duration and intensity of the therapy and the time lapse following termination. Entering into a social relationship a year after having met two or three times to discuss a specific crisis is less likely to cause difficulty than entering into a business partnership two months after extended psychotherapy has terminated. One must be mindful that establishing a second relationship may deprive the patient of the opportunity to return for further psychotherapy (Gabbard, 2005). It is also important to appreciate that the therapeutic alliance does not end with the termination of therapy. The patient's thoughts and feelings about the role his therapist and the therapy process played in his life remain with him forever. Decades after my own therapy ended, I was caught off guard when I met up with my therapist at a meeting. I was surprised at how

emotional that moment was for me as a rush of feelings returned—the memory of emotional pain and vulnerability mixed with affection and gratitude. It was as if it were yesterday.

Self-Disclosure

When I began my career I had been instructed to avoid self-disclosure. Self-disclosure was self-indulgent; it took up time that should be spent focused on the patient's life (*Enough about you; let me tell you about my suffering*); it interfered with the patient's projection of thoughts and feelings about the therapist because it filled in the empty space (*I didn't know you had no children; I assumed you did*); and it inhibited the patient's self-revelations (*Now that I know you are a Democrat, I can't tell you how Republican I am*). For many of us who were uncomfortable sharing aspects of our personal life, this rule was something we could lean on. In retrospect, this seems to have been an unfortunate introduction to therapy because self-disclosure, when done thoughtfully and purposefully, can be extraordinarily useful. If we are to believe that the positive therapeutic alliance is an important curative factor, then we must behave like real people coping with conflicts and dilemmas of our own, not therapeutic robots whose lives are problem-free.

Often self-disclosure issues come up before therapy has even begun. Prospective patients may have specific requirements for whom they want to see in terms of gender, age, marital status, religious background, professional discipline, modality of practice, and personality style. This is especially true of members of a minority culture or race such as Orthodox Jews or Afro-Americans, or people who are handicapped in some way such as those who are sight or hearing impaired, who may not trust that someone outside of their identity can be trusted and/or helpful. To a large degree, patients have a right to that information, and therapists usually choose to answer those questions so that the patient can make an informed choice. It is often helpful, however, to first inquire why the patient cares about a particular factor, because the reason behind it is not always rational or relevant to good care. For example, a patient might insist on seeing a psychiatrist instead of a psychologist or social worker or vice versa because they have pre-conceived ideas about who does better therapy. Or they may think that only a married therapist can do marital counseling or only a parent can do parent guidance. Gentle questioning can reveal their concerns and counter them if applicable with another point of view. Obviously, patients generally have the final word even if their choice does not appear wise.

By the same token, therapists disclose much about themselves from the very beginning of therapy by the location of their practice, their office decor, their manner of dress, and their interpersonal style. It is indeed a balancing act of being thoughtful of how we come across to patients (not dressing too casually or too formally, decorating one's office attractively but not making it a showroom of one's personal life), on the one hand, and being true to oneself and a real person, on the other.

In the therapy hour, self-disclosure can take several forms. One might tell a story about one's own life to demonstrate a personal understanding of the patient's narrative.

Patient: (crying): I'm sorry I had to cancel last week, but my dog was sick and I couldn't leave her. I had to put her down the next day, and I haven't been able to stop crying.

Therapist: I can imagine how awful you felt. I once had a dog I had to put down, and it haunted me for a long time.

Patient: I'm so glad you said that. My husband thinks I should be over it by now, and even my friends don't seem to understand.

Notice that the therapist does not launch into a long story about the loss of her dog. This is not a discussion between mutual friends who share equal time in commiserating. The therapist's comment merely conveys an empathic response to the patient's grief.

Self-disclosure can also take the form of sharing one's reactions to something the patient is saying or doing. This can be therapeutic if it is expressed with the goal of wanting to understand what might be going on with the patient.

Therapist: You've made several offhand comments today that suggest you might be angry with me about something.

Patient: Really? Whatever I said, I was just kidding. Can't you take a joke?

Therapist: I think I can. But do you think you might be angry with me about something?

Patient: No, absolutely not. I think you are having a bad day!

Therapist: Well, last week was a rough session, and just before you left, you said you didn't know if coming here was worth it. I wonder if you were upset at my attempts to have you confront some pretty painful feelings. One way to make sure we don't go there today is to poke at me and keep your distance.

Patient: I was very upset last week. But I thought I got over it. How can I blame you for doing your job? You are right, though. I didn't really want to come today. I almost made up an excuse to cancel.

In this case, the therapist did not get defensive when the patient briefly turned it on him by suggesting he was having a bad day. Making this type of intervention, however, requires checking in with oneself first to make sure one's feelings are in response to something the patient is doing and not just the product of a "bad day" or something else going on in the one's own life or mind independent of the patient.

Who Has Sex With a Patient?

Most of us will never engage in sexual intimacies with a patient. It is also true that most therapists who do end up crossing this boundary never imagined that they would act this way. If there are personal characteristics or situations that we or our patients are experiencing that make us more vulnerable to crossing this type of boundary, it would certainly be helpful to know what these risks are. A word of caution, however: a retrospective view of the factors that may have contributed to a boundary violation cannot be used to formulate predictions of future violations based on current factors.

Risk factors that contribute to boundary violations have been discussed by several authors (Gabbard, 2005; Rutter, 1989; Schoener, 1995; Streat, 1993) who specialize in these problems. The agreed-upon risks include lack of training, mental illness, severe character pathology, and presence of a sexual compulsion or addiction. Most authors conclude, however, that the vast majority of therapists who violate boundaries do so in the midst of a personal crisis during which their own needs are neither addressed nor cared for.

It is a well-known adage that in order to effectively care for the needs of clients, therapists must have their own needs adequately cared for. But the truth is most of us will experience at least one period in our life that we would identify as a personal crisis: the break-up of a relationship, the death of a friend or family member, physical illness, or vocational failure. During those times, we may well feel that our personal life has become unmanageable and that we cannot get our needs met. Does that mean we should not practice during such a period? The answer depends on the severity of the situation and our ability to recognize and manage those unmet needs and personal vulnerabilities so as not to bring them into the office setting. In the acute phase of the crisis, it might be wise to take a few days off. But that is impractical in the long run. Self-awareness and self-care are crucial, that is, the ability to recognize one's vulnerabilities (loneliness, anxiety, depression, guilt, or low self-esteem) and to make sure those feelings don't spill over to the therapist-client relationship in a way that invites the patient to "lean in" and offer comfort. When that shift does take place, the

newfound mutual exchange of emotional intimacy can easily become eroticized, especially when the patient fits the therapist's "object of interest" in terms of age, perceived attractiveness, personality appeal, and sexual orientation. Likewise, to the extent that the therapist "fits the bill" for the patient, the potential for erotic feelings is greater. Thus, the dyad most at risk for a sexual boundary violation is the one in which the therapist and client meet each other's criteria for sexual interest and appeal and are each needy for affection, affirmation, and love because of current voids in their personal lives.

Conclusion

I have suggested to you that you will judiciously cross many boundaries during your career because therapy is a flexible, creative process that requires a constant re-evaluation of how best to serve the needs of the client. If a therapist rigidly adheres to a set of principles and rules and never ventures outside them, it is unlikely that the client will experience therapy as a humanistic, nurturing, and growth-promoting process.

There will be times when you will be tempted to cross boundaries you sense you shouldn't and will struggle with the conflict between your impulse and your larger wise understanding of what is at stake for you and the patient. Please do not be dismayed by your impulses and do not judge your colleagues for theirs. Our impulses, however misguided and uncivilized at times, are valuable sources of information about ourselves and our clients, if we examine them with intellectual curiosity and respect. Therapists who are early in their careers will become increasingly comfortable and skillful at this as clinical experience accumulates. It is part of the maturational process of professionalism. It is critical that you have a professional network of colleagues with whom you can periodically discuss these issues. Utilizing their perspective and guidance is the best way to ensure that you remain grounded in your commitment to provide the best possible care for your patients.

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