

Boundary Crossings & Boundary Violations In Psychotherapy

Key Points

1. Boundary violations and boundary crossings in psychotherapy refer to any deviation from traditional, strict, 'only in the office,' emotionally distant forms of therapy. They mostly refer to issues of self disclosure, length and place of sessions, physical touch, activities outside the office, gift exchange, social and other non-therapeutic contact and various forms of dual relationships. Basically, they may all be seen as a departure from the traditional psychoanalytic proceedings.
2. Boundary violations in therapy are very different from boundary crossings. While boundary violations by therapists are harmful to their patients, boundary crossings are not and can prove to be extremely helpful.
3. Harmful boundary violations occur typically when therapists and patients are engaged in exploitative dual relationships, such as sexual contacts with current clients. Exploitative business relationships also constitute boundary violations.
4. Boundary crossings can be an integral part of well formulated treatment plans or evidence-based treatment plans. Examples are, flying in an airplane with a patient who suffers from a fear of flying, having lunch with an anorexic patient, making a home visit to a bed ridden elderly patient, going for a vigorous walk with a depressed patient, or accompanying a patient to a dreaded but medically essential doctor's appointment to which he or she would not go on their own.
5. Potentially helpful boundary crossings also include going on a hike, giving a non-sexual hug, sending cards, exchanging appropriate (not too expensive) gifts, lending a book, attending a wedding, confirmation, Bar Mitzvah or funeral, or going to see a client performing in a show.
6. Boundary crossings are not unethical. Ethics code of all major psychotherapy professional associations (e.g., APA, ApA, NASW, ACA, NBCC) do not prohibit boundary crossings, only boundary violations. [Ethics Codes for therapy](#)
7. Therapeutic orientations, such as humanistic, behavioral, cognitive, behavioral, family systems, feminist or group therapy are more likely to endorse boundary crossings as part of effective treatment than analytically or dynamically oriented therapies.
8. As with dual relationships, what constitutes harmful boundary violations according to one theoretical orientation may be considered helpful boundary crossings according to another orientation.
9. Like dual relationships, boundary crossings are normal, unavoidable and expected in small communities such as rural, military, universities and interdependent communities such as the deaf, ethnic, gays, etc.
10. Different cultures have different expectations, customs and values and therefore judge the appropriateness of boundary crossings differently. More communally oriented cultures, such as the Latino, African American or Native Americans, are more likely to expect boundary crossings, and frown upon the rigid implementation of boundaries in therapy.
11. Not all boundary crossings constitute dual relationships. Making a home visit, going on a hike, or attending a wedding with a client and many other 'out-of-office' experiences are boundary crossings which do not necessary constitute dual relationships. Similarly, exchanging gifts, hugging, or sharing a meal are also boundary crossings but not dual

relationships. However, all dual relationships, including attending the same church, bartering, playing in the same recreational league, constitute boundary crossings.

12. There is a prevalent erroneous and unfounded belief about the 'slippery slope' that claims that minor boundary crossings inevitably lead to boundary violations and sexual relationships. This somewhat paranoid approach is based on the 'snow ball' effect. It predicts that the giving of a simple gift likely ends up in a business relationship. A therapist's self disclosure becomes an intricate social relationship. A non-sexual hug turns into a sexual relationship.
13. A rigid attitude towards boundary crossings stems, in part, from what has been called 'sexualizing boundaries.' This is another distorted view that sees all boundary crossings as sexual in nature.
14. Boundary crossings with certain clients, such as those with borderline personality disorder, must be approached with caution. Effective therapy with some clients may require a clearly structured and well-defined therapeutic environment.
15. As with dual relationships, boundary crossings should be implemented according to the client's unique needs and the specific situation. It is recommended that the rationale for boundary crossings be clearly articulated and, when appropriate, included in the treatment plan.
16. The meaning of boundaries and their appropriate application can only be understood and assessed within the **context of therapy**. The context of therapy consists of four main components: clients, setting, therapy and therapists.
 - **Client factors** include: Culture, history -- including history of trauma, sexual and/or physical abuse -- age, gender, presenting problem, mental state and type and severity of mental disturbances, socio-economic class, personality type and/or personality disorder, sexual orientation, social support, religious and/or spiritual beliefs and practices, physical health, prior experience with therapy and therapists, etc.
 - **Setting factors** include: Outpatient vs. inpatient; Solo practice vs. group practice; Office in medical building vs. private setting vs. home office; Free-standing clinic vs. hospital based clinic; Privately owned clinic vs. publicly run agency; The presence or proximity of a receptionist, staff or other professionals. It also includes Locality: Large, metropolitan area vs. small, rural town vs. Indian reservation; Affluent, suburban setting vs. poor neighborhood vs. university counseling center; Major urban setting vs. remote military base, prison or police department setting.
 - **Therapy factors** include:

Therapeutic factors, such as modality: Individual vs. couple vs. family vs. group therapy; Short term vs. long term vs. intermittent long-term therapy; Intensity: Therapy sessions several times a week vs. once a month consultation; Population: Child vs. adolescent vs. adult psychotherapy; Theoretical Orientation: Psychoanalysis vs. humanistic vs. group therapy vs. body psychotherapy vs. eclectic therapy.

Therapeutic relationship factors: Quality and nature of therapeutic alliance, i.e., secure, trusting, tentative, fearful or safe connection. Intense and involved vs. neutral or casual relationships; Length, i.e.,

new vs. long-term relationship; Period, i.e., beginning of therapy vs. middle of therapy vs. towards termination; Idealized/transferential relationships vs. familiar and more egalitarian relationships; Familiarity and interactivity in the community vs. only in the office, distanced relationship; Presence or absence of dual relationships and type of dual relationships, if applicable.

- **Therapist factors** include: Culture, age, gender, sexual orientation; Scope of practice (i.e., training and experience).

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