To Cross or Not To Cross: Ethical Boundaries in Psychological Practice

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Abstract

This article examines multiple relationships and discusses ethical boundaries in psychology practice. Correct handling of potential multiple relationships is important for staff at educational facilities, where students may simultaneously act as counselling clients, teaching assistants, peer supervisors, supervisees, mentors, mentees, research partners, etc. The basis for the discussion includes the role of the client-therapist power differential, fiduciary duty and the code of ethics. An overview is given regarding types of multiple relationships, differentiation between potentially beneficial boundary crossings and potentially detrimental boundary violations and the 'slippery slope' concept. Taxonomy of boundary violators considers individual differences, incompetence and situational circumstances. Recommendations for risk management include training in ethical standards and decision making techniques, self-awareness, supervision and adherence to good professional standards in general. Opportunities for further research include the correction of methodological errors in older surveys, more research regarding the efficacy of training and interventions for boundary violations and efforts to provide more tools for risk assessment. It is important to acknowledge that differentiation between boundary crossings and boundary violations can be challenging: whilst practitioners always need to guard against boundary violations, the literature offers examples where boundary crossings may be therapeutic. Ultimately, the therapist makes a choice about how to deal with any given boundary; and the therapist needs to make this choice from the viewpoint of fiduciary duty with the client's best interest in mind.

The Australian Psychological Society has recently released new guidelines for dealing ethically with multiple relationships ("Revised APS ethical guideline", 2016). The psychological profession has a long history of trying to prevent unethical multiple relationships via prohibitions and ethics codes (Ivey & Doenges, 2013), but it similarly has a long history of unethical relationships between psychologists and their clients (Gottlieb & Younggren, 2009). The present article examines multiple relationships. The ethical basis for the discussion of multiple relationships is reviewed, and multiple relationships, boundaries, boundary crossings, boundary violations are defined and their interconnectedness are examined. Recommendations for managing the risk of boundary violations are made, including requirements for training; and opportunities for further research are suggested. It is posited, that, ultimately, the therapist makes a choice about how to deal with boundaries and multiple relationships. The therapist needs to make this choice from the viewpoint of fiduciary duty with the client's best interest in mind.

Ethical Basis

Power differential

Any discussion of professional ethics in psychology must acknowledge the power differential that exists between the therapists and clients. The literature attributes this power differential primarily to the therapists' expert knowledge and the patients' role as seeking help (DeLeon, 2001). However, power issues are not restricted to the configuration of therapist and patient. Power differentials can also exist in such diverse situations as, for example, internship settings (Slimp & Burian, 1994), research projects (Haverkamp, 2005), community psychology (Perlman, 1977) or sport performance psychology (Aoyagi & Portenga, 2010).

Fiduciary duty and codes of ethics

Given the psychologist's position of power, any client-therapist relationship is automatically a fiduciary, i.e. a trust relationship; in that the psychologist's first and foremost concern should be the client's best interest (Smith, J.A., Pomerantz, Pettibone, & Segrist, 2012; Sonne, 1994). Fiduciary relationships in psychological

practice are covered by the professional codes of ethics that exist in many countries, including Australia, New Zealand, and the United States (Allan & Love, 2010; Barnett, 2014). These national professional codes of ethics all stress in various forms the importance of clear boundary delineations in providing clarity (Sawyer & Prescott, 2010), preventing harm (Jorgenson, Hirsch, & Wahl, 1997) and giving the client a sense of safety (Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007).

Multiple Relationships

Definition of multiple relationships

Multiple relationships in psychological practice refer to situations where multiple roles exist between therapist and client (Barnett, 2014). Multiple relationships are distinct from incidental contacts, such as passing a client in the grocery store (Werth, Hastings, & Riding-Malon, 2010).

Types of multiple relationships

Multiple relationships can occur concurrently, consecutively or sequentially to the established relationship (Lamb, Catanzaro, & Moorman, 2004). Multiple relationships are classified most commonly as non-professional (e.g., social, familial, communal and business) and professional (e.g., non-therapy-professional, institutional and therapeutic) relationships (Slimp & Burian, 1994). Notably, multiple relationships are not static and can evolve or change over time (Davidson, 2006).

Non-professional multiple relationships.

Non-professional multiple relationships include social relationships, such as membership of a therapist and a client in the same social club (Campbell & Gordon, 2003); familial relationships, such as a relationship between a therapist and a client's family member (Werth et al., 2010). Non-professional multiple relationships also include business relationships, where therapist and client are business partners or one employs the other (Lamb et al., 2004) and communal relationships, where the therapist and client live in the same community or attend the same place of worship (Campbell & Gordon, 2003). Communal multiple

relationships are common in rural areas, where the social network is denser than in urban areas (Helbok, Marinelli, & Walls, 2006) and where distance from and availability of services is an issue (Osborn, 2012).

Professional multiple relationships.

Professional multiple relationships are evident in a range of professional situations. The treatment-professional relationship is where a therapist also provides non-therapeutic professional services (Lamb et al., 2004), while the non-treatment-professional relationship may locate the practitioner and client as colleagues (Sonne, 1994) and not involved in a therapeutic relationship (Younggren & Gottlieb, 2004). Multiple professional relationships are also observed where the psychologist acts as a consultant, such as in sports performance psychology (Aoyagi & Portenga, 2010) and community and organisational psychology (O'Neill, 1989), and also where a therapist also acts as a forensic expert witness in legal proceedings that involve their therapy client (Greenberg & Shuman, 1997). Such forensic relationships are strongly discouraged due to the conflicting goals of therapy and psycho-legal assessment and potential harm to the client (Greenberg & Shuman, 1997). Supervisory relationships also involve professional multiple relationships, as the practitioner may be both supervisor and superior, such as during internships, graduate study, or as part of professional supervision (Seto, 1995).

Institutional multiple relationships.

A special category of multiple professional relationships is institutional relationships, which occur, for instance, in the military, in correctional facilities, or in educational situations. Military psychologists face a particular dilemma in that they are both a psychologist and a commissioned officer, and thereby subject to the psychological code of ethics as well as the applicable defence legislation, which sometimes conflict. Extreme examples of this conflict are a case where a military psychologist's compliance with the Code of Ethics of the American Psychological Association resulted in a reprimand for violating the legislation governing the Unites States Department of Defence, and conversely, another military psychologist's compliance with Defence legislation resulted in a sanction for a violation of the

Code of Ethics of the American Psychological Association (Staal & King, 2000). Additionally, the military psychologist often has difficulty in ascertaining who the client is - is it the recipient of the therapy or the military organisation (Staal & King, 2000)? Moreover, the military psychologist in a combat situation might be obliged to provide therapy to subordinates; friends etc., as there are no other psychologists available. This is comparable to the remoteness and scarcity of service in rural situations (Staal & King, 2000). However, in the military context, the psychologist-officer holds a further exalted position of authority regarding a client's life, which intensifies the power differential (Johnson, 2008).

The institutional multiple relationships found in correctional facilities occur where therapy, assessment and custody-oriented roles may be mixed and therapeutic and security goals may conflict (Haag, 2006; Weinberger & Sreenivasan, 1994). Such multiple roles become even more pronounced in cases of involuntary therapy of sexual offenders, where therapeutic roles may be confounded with parole board duty (Sawyer & Prescott, 2010).

Multiple relationships also occur at educational facilities, where students may simultaneously act as counselling clients, teaching assistants, peer supervisors, supervisees, mentors, mentees, research partners, etc. (Sharkin, 1995). In qualitative research projects, where there is an intense connection between researcher and research subject, the boundaries may be blurred (Appelbaum & Rosenbaum, 1989).

In summary, multiple relationships can arise in many settings. Not all of these can be avoided, and some multiple relationships are even mandatory, as in the case of military or correctional psychologists. Therefore, it is imperative that the practitioner remain focused on the client's best interest and the maintenance of appropriate professional boundaries (Sawyer & Prescott, 2010).

Boundaries

Definition of boundaries

Boundaries are defined as the limits of what is appropriate in a given circumstance (Gutheil & Gabbard, 1993). While boundaries

are inherent to all human relationships, they become most salient in professional psychological practice, with the onus being upon the psychologist to ensure appropriate boundaries are maintained (Jorgenson et al., 1997). The literature differentiates between structural and interpersonal boundaries (Sawyer & Prescott, 2010). Structural boundaries include details such as time and location of appointments and billing practices (Jorgenson et al., 1997). Interpersonal boundaries include concerns such as gifts, self-disclosure, and physical contact (Sawyer & Prescott, 2010).

Setting boundaries

Boundary setting is influenced by external circumstances, cultural context and theoretical orientation of the practitioner, type of treatment, therapist intentions and reception by the client. External circumstances, for instance, could be the practitioner's location in a rural area or on a military base (Jorgenson et al., 1997). Cultural context is exemplified by differing cultural norms regarding boundaries for gift giving or self-disclosure (Barnett, 2014). The influence of the theoretical orientation of the practitioner is illustrated by the different attitudes to self-disclosure that traditional psychotherapists have compared to humanist psychotherapists (Zur, Williams, Lehavot, & Knapp, 2009). The nature of the treatment also influences the delineation of boundaries; for example, insight therapy may require stricter boundaries than cognitive behavioural therapy (Younggren & Gottlieb, 2004). Lastly, it is important to consider the therapist's intent and the client's response to the proposed boundaries (Barnett, 2014).

Boundary crossings

When a therapist deviates from the commonly accepted practice but the client is not harmed, then this is classified as a boundary crossing (Gutheil & Gabbard, 1993; Sawyer & Prescott, 2010; Sude, 2013). The literature offers many examples of positive therapeutic boundary crossings, two of which are gift acceptance and self-disclosure (Barnett et al., 2007).

Gift acceptance.

One such boundary crossing concerns accepting gifts from clients.

While the traditional view of gift acceptance was that the therapist should not accept gifts from a client under any circumstances, recently the opposite view has gained traction (Knox, Dubois, Smith, Hess, & Hill, 2009). Proponents of gift acceptance argue, for instance, that rejecting a small token gift for ethical reasons might be interpreted by the client as a rejection of their person and endanger the therapy's success (Knox et al., 2009).

Self-disclosure.

Another example concerns self-disclosure by the therapist. Psychologists increasingly view self-disclosure as both safe and unavoidable (Barnett, 2014) and even outright therapeutic (Gutheil, 1999). For example, clients who feel marginalised due to minority group membership may experience affirmation from therapist self-disclosure (Barnett et al., 2007). Moreover, practitioners of cognitive behaviour therapy might use self-disclosure to enrich the process of modelling and norming for the client (Zur et al., 2009). However, practitioners are cautioned against excessive self-disclosure that could lead to boundary confusion (i.e., starting to view the client as a personal friend) and subsequent loss of the therapist's objectivity (Gabbard, 1997). A case-by-case assessment of the appropriateness of self-disclosure is necessary, as self-disclosure might be therapeutically beneficial in one case but detrimental in another (Gutheil, 1999).

Boundary violations

In contrast to boundary crossings, boundary violations are defined by the harmful and exploitative aspect of the action (Gutheil & Gabbard, 1993). Boundary violations can be non-sexual or sexual.

Non-sexual boundary violations.

Examples of non-sexual boundary violations include accepting inappropriately large gifts from the client or issuing invitations to the therapist's home (Jorgenson et al., 1997), extending appointments inappropriately (Swiggart, Feurer, Samenow, Delmonico, & Spickard Jr, 2008) or engaging in excessive self-disclosure (Barnett et al., 2007). Non-sexual boundary violations can unbalance the client-therapist-relationship and thereby undermine the therapy's progress and potentially harm

the client (Pope & Keith-Spiegel, 2008).

Sexual boundary violations.

Sexual boundary violations are considered to be the most egregious examples of boundary violations (Wierzbicki, Siderits, & Kuchan, 2012), and, due to the strong potential for harm, are prohibited by many professional codes of practice, including the American Psychological Association (Barnett, 2014) and the Australian Psychological Society (Allan & Love, 2010). Historically, many psychologists considered post-termination sexual relationships unproblematic (Lamb et al., 2003). Recently, however, the profession increasingly seeks to ban all sexual relationships with clients, including late-onset post-termination relationships (Appelbaum & Jorgenson, 1991; Seto, 1995). It is noteworthy that 80% of boundary violators sought peer consultation in an effort to handle the overwhelming sexual attraction to their client (Lamb et al., 2003).

Effects of boundary violations.

The literature cites many negative effects of boundary violations, including loss of objectivity by the therapist and harm to the client, ranging from discomfort to severe anxiety, suicide and hospitalisation (Seto, 1995). Boundary violations also negatively affect the community in which the client and therapist are embedded (Slimp & Burian, 1994), the profession's reputation (McNulty, Ogden, & Warren, 2013), and the therapist's capacity to practice (Lamb, Catanzaro, & Moorman, 2003). Observations of positive effects in relation to boundary violations are rare and are usually concurrent to and overshadowed by negative effects (Seto, 1995). Moreover, these positive effects are reported by the inflicting therapists and possibly constitute bias rather than genuine observations (Seto, 1995).

Differentiating between boundary crossings and boundary violations

The literature emphasises that all multiple relationships, by definition, involve boundary crossings, but not necessarily boundary violations (Tirpak & Lee, 2012). To differentiate between boundary crossings and boundary violations can be

challenging (Barnett et al., 2007). This is exacerbated by the context of the situation, including cultural norms: what is considered acceptable in one culture might be a boundary violation in another culture (Barnett et al., 2007), as exemplified by varying propensities for and acceptance of physical touch as a form of greeting. The differentiation between boundary crossings and violations is filtered through an individual's interpretation of the situation (Heaton & Black, 2009); for instance, a proffered gift may appear large to a low-earning staff psychologist but small to a high-earning owner of a successful psychological practice. The increasing use of social media makes it harder to ring-fence personal information, which can lead to accidental self-disclosure (Hammond & O'Donovan, 2015), and overly casual online communication could constitute a boundary violation (Sude, 2013).

The *slippery slope* from boundary crossing to boundary violation

The potential of a correlation between boundary crossings and boundary violations is a hotly debated topic referred to as the slippery slope from boundary crossing to boundary violation, which is a term coined by Gutheil and Gabbard (1993). Proponents of the slippery slope hypothesis argue that seemingly minor boundary crossings lead to a cascade of increasingly larger boundary crossings, non-sexual boundary violations and eventually sexual boundary violations (Gutheil & Gabbard, 1993). This view was historically widely accepted, and, as a result, psychologists were advised to be extremely conservative in their risk management and avoid all potential boundary crossings (Gutheil & Gabbard, 1993, 1998). More recent studies have found no correlation between boundary crossings and boundary violations and no conclusive evidence that boundary crossings inevitably lead to boundary violations (Gottlieb & Younggren, 2009). Newer literature points out that the slippery slope concept may harm clients by prohibiting boundary crossings that might be therapeutic (Barnett, 2014). Examples are rejecting a small holiday gift from a child (Barnett, 2014), refusing to extend a session for a client in crisis (Barnett et al., 2007), shaming ethnically diverse clients by refusing an ethnic greeting ritual that involves touching (Barnett et al., 2007), or denying service to a client in a rural

setting due to overly strict avoidance of multiple relationships (Osborn, 2012). Notably, the legal system still subscribes to the original slippery slope hypothesis: a therapist guilty of minor non-sexual boundary crossings is also assumed to have engaged in sexual boundary violations (Gutheil & Gabbard, 1993).

Given the varied contexts and circumstances that differentiate boundary crossings from boundary violations, and the question as to whether the former will predicate the latter, it is important to acknowledge that, ultimately, the therapist makes a choice about how to deal with any given boundary (Campbell & Gordon, 2003; Ivey & Doenges, 2013; Sawyer & Prescott, 2010). The therapist needs to make this choice from the viewpoint of fiduciary duty with the client's best interest in mind (Jorgenson et al., 1997).

Taxonomy of boundary violators

Various attempts at a taxonomy of boundary violators have been made (Barnett, 2014). The considered aspects can be roughly grouped into three categories: individual characteristics, lack of competence, and situational circumstances of the perpetrators.

Individual characteristics

Individual differences considered to be predictors for boundary violations include prior experiences of violations (Lamb et al., 2003), particular vulnerability to transference (Perlman, 2009), affinity to risk taking (Lamb et al., 2003), defensive or self-aggrandising personality styles (Celenza & Gabbard, 2003), overcompensating for hostility (Gabbard, 1997), commanding strong authority and respect (Ruskin, 2011), hostility towards authority (Perlman, 2009), and a tendency towards narcissism and sociopathy (Celenza & Gabbard, 2003). However, narcissists and sociopaths constitute a minority, with most transgressions more likely being perpetrated due to incompetence or situational factors (Celenza & Gabbard, 2003).

Incompetence

Incompetence includes situational misinterpretations (Perlman, 2009), cognitive errors (Pope & Keith-Spiegel, 2008), difficulty in setting boundaries with demanding clients (Gabbard, 1997),

mismanagement of transference from the client (Gutheil & Gabbard, 1993), and the challenges related to supportive modalities of therapy, which include more opportunity for transference and less availability of training (Gabbard, 1997). One notable cognitive error is that therapists assume a client's consent to boundary violations as being valid; however, in light of the fiduciary nature of the client-therapist relationship, the power differential and the potential for transference, even competent consenting adults may be subject to undue influence, and it could, therefore, be argued that client-consent in a client-therapist relationship is invalid (Slimp & Burian, 1994).

Situational circumstances

The literature considers several situations and circumstances that may make a therapist more likely to engage in boundary violations. These include personal dissatisfaction (Lamb et al., 2003), crisis events such as divorce, death or litigation, prolonged excessive self-deprivation (Celenza & Gabbard, 2003), and stress (Gabbard, 1997).

In summary, there is a substantial literature giving insight into aspects of boundary violations. This helps to inform recommendations for minimising the occurrence of boundary violations.

Recommendations to prevent the occurrence of boundary violations

Ethics Training

There are many recommended options to decrease the incidence of boundary violations. Firstly, given the correlation of boundary violations with lack of ethics training, one very important recommendation is to ensure sufficient training in ethical standards. Inherent to this recommendation is the requirement to reliably measure the efficacy of such training.

Risk management training

Secondly, training in risk assessment and decision making techniques is recommended (Barnett et al., 2007; Heaton & Black, 2009). Again, it is important to reliably measure the efficacy of

such techniques.

Professional standards

In addition to the above recommendations, good professional standards also include a number of general recommendations that also act as defences against boundary violations. This includes practising self-awareness (Barnett, 2014), participating in supervision and consultation (Celenza & Gabbard, 2003), keeping good client documentation and considering drafting one's own policies for dealing with boundaries (Younggren & Gottlieb, 2004).

Suggestions for further research

There are several avenues for further research. Firstly, the literature notes methodological errors and limitations in previous surveys regarding self-reports, retrospective reports and sampling bias (Seto, 1995) – new surveys could be designed with improved methodologies to avoid these limitations.

Secondly, further research is needed regarding the efficacy of training and interventions in regard to boundary violations (Seto, 1995). Measures need to be developed to simplify the assessment of training methods to ensure future psychologists are getting sufficient high quality ethics training to yield results in teaching the skills necessary to handle boundary conflicts.

Lastly, more risk assessment techniques and tools such as the Boundary Violation Index are needed to help with the risk assessment for boundary violations (Swiggart et al., 2008). Moreover, more measures need to be developed to assess the effectiveness of such tools and techniques.

Conclusion

In conclusion, it is important to acknowledge that differentiation between boundary crossings and boundary violations can be challenging: whilst practitioners always need to guard against boundary violations, the literature offers examples where boundary crossings may be therapeutic. Ultimately, the therapist makes a choice about how to deal with boundaries and potential

multiple relationships. The therapist needs to make this choice from the viewpoint of fiduciary duty with the client's best interest in mind.

The present article examined multiple relationships. The ethical basis for the discussion of multiple relationships was reviewed, and multiple relationships, boundaries, boundary crossings, boundary violations and their interconnectedness were examined. Recommendations for managing the risk of boundary violations were made, including requirements for training. Moreover, it was suggested that future research should attempt to correct previous methodological errors, further examine the efficacy of training and interventions for boundary violations and provide more tools for risk assessment for boundary violations and reliable measures for assessing their efficacy.

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