A Practical Approach to Boundaries in Psychotherapy: Making Decisions, Bypassing Blunders, and Mending Fences

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Abstract: Nonsexual boundary crossings can enrich psychotherapy, serve the treatment plan, and strengthen the therapist-client working relationship. They can also undermine the therapy, disrupt the therapist-patient alliance, and cause harm to clients. Building on Gutheil and Gabbard's (1993) conceptualization of boundary crossings and boundary violations, this article discusses and illustrates grounding boundary decisions in a sound approach to ethics. We provide 9 useful steps in deciding whether to cross a boundary, describe common cognitive errors in boundary decision-making, and offer 9 helpful steps to take when a boundary crossing has negative effects.

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Each of us confronts boundary issues on a daily basis. “My client seems in crisis -- should I let the session run overtime?” “What should I say to my best friend who wants me to see his young daughter in psychotherapy” “Is it a good idea for me to waive the fee for a proud client who desperately needs therapy, lost his job, and is unable to find other work?” “Should I attend my client's wedding and bring a gift?” “My new client is known for giving great parties and has invited me -- should I go?” “I wonder what I should say to the tournament organizers -- I really want to win but they've paired me with my therapy client as a doubles-partner Does it matter that my client has a lousy serve, a nonexistent backhand, and wilts under pressure?”

Controversies, Research, and a Landmark Article

Beginning in the early 1980s, these questions seized and held the field's attention. A search of APA’s PsychInfo database turned up over 1,500 books, articles, and dissertations on the topics of boundaries, dual role relationships, and the like. The 15 years running from the 1980s through the mid-1990s saw a virtual explosion of healthy controversy and thoughtful writings on dual relationships, bartering, nonsexual touch, meeting therapy clients outside the office for social visits, and other nonsexual boundary issues. Should all prohibitions be abolished? Was it possible to tell which boundary crossings were therapeutically helpful, which were therapeutically contra-indicated as harmful, which might be common or even unavoidable in certain communities or cultures?

Research during the 80s and 90s demonstrated how theoretical orientation, size of the local community, therapist gender, client gender, profession, and other factors affected both the
degree to which therapists engaged in crossing various boundaries and therapists' beliefs about the nature and appropriateness of boundary crossings.

“The Concept of Boundaries in Clinical Practice,” a landmark article by Gutheil and Gabbard (1993), represented a turning point for the field. It provided a useful framework for thinking through and challenging beliefs, for providing thoughtful explorations, for learning from and arguing against, for understanding the history and development of this area, and for helping to think through difficult decisions in our day-to-day clinical work.

These authors cast a new light on the historical context of boundaries. While noting that many who endorse inflexible boundaries rely on Freud as an authority, they described how Freud himself sometimes sent postcards to his patients, lent them books, gave them gifts, talked with them about his own family members, shared meals with an analytic patient while on vacation, conducted an analysis while walking through the countryside, and analyzed his own daughter.

Gutheil and Gabbard organized the individual instances of boundary crossings like Freud's that were described in the literature, the emerging research, and the diverse viewpoints as a basis for their initial "explorations," and developed a framework of boundary crossings and boundary violations that reflected the realities of clinical practice. Judgments were made in light of the context and specifics:

If this exploration is to be useful, we should adopt the convention that "boundary crossing" in this article is a descriptive term, neither laudatory nor pejorative. An assessor could then determine the impact of a boundary crossing on a case-by-case basis that takes into account the context and situation-specific facts, such as the possible harmfulness of this crossing to this patient. A violation, then, represents a harmful crossing, a transgression, of a boundary. (p. 190)

Gutheil and Gabbard examined crossings and violations of such diverse boundaries as role, time, place and space, money, gifts, services, clothing, language, self-disclosure, and physical contact. They emphasized that crossing boundaries "may at times be salutary, at times neutral, and at times harmful" and that the nature, clinical usefulness, and impact of a particular crossing "can only be assessed by a careful attention to the clinical context" (pp. 188-189).

Finally, these authors noted that some regulatory bodies had difficulty addressing boundary issues in disciplinary actions in a way that took account of theoretical orientation and other contexts, was consistent with the research, and was fair to the therapist. They addressed their concerns about this aspect in much more detail in their subsequent widely-cited and influential article a few years later: "Misuses and misunderstandings of boundary theory in clinical and regulatory settings" (Gutheil & Gabbard, 1998).

**Boundary Decisions in Context**
The landmark 1993 article described in the previous section provided a framework in which our decisions about whether to cross a specific boundary in psychotherapy with a specific client at a specific time and for a specific reason are informed by attending carefully to context of that therapy, that therapist, that client, and so on. But a decision about whether to cross a boundary must be made in the context of a more general approach to ethics. Sometimes the intense focus on boundaries, the historic controversies, and the uncertainty and anxieties that some boundary issues evoke can make it seem as if decisions about boundaries are a strange and forbidding aspect of our work, calling for a special set of decision-making rules that are isolated from the more general ethics of our work. We believe that thoughtful consideration of boundaries must be solidly grounded in our basic approach to ethical decision-making.

People differ in their ability to perceive that something they might do, or are already doing, could directly or indirectly affect the welfare of others (see, e.g., Rest, 1982). Below are a few of the most basic assumptions we make about the ethical awareness and decision-making, as adapted from our ethics texts (Koocher & Keith-Spiegel, 2008; Pope & Vasquez, 2007).

1. Ethical awareness is a continuous, active process that involves constant questioning and personal responsibility. Conflicts with managed care companies, the urgency of patients' needs, the possibility of formal complaints by patients or second-guessing by colleagues about a difficult boundary decision we make, mind-deadening routines and endless paperwork, worrying about making ends meet, fatigue, and so much else can begin to block our personal responsiveness and dull our sense of personal responsibility. They can overwhelm us, drain us, distract us, lull us into ethical sleep, and make us more vulnerable to the tendency we all share as human beings to rationalize our questionable decisions. It is crucial to practice continued alertness and mindful awareness of the ethical implications of what we choose to do and not do.

2. Awareness of ethical codes and legal standards is an essential aspect of critical thinking about ethics and of making ethical decisions. Codes and standards, however, inform rather than determine our ethical decisions. They cannot substitute for thinking and feeling our way through ethical dilemmas, and cannot protect us from ethical struggles and uncertainty. Each new client, regardless of similarities to other clients, is unique. Each therapist is unique. Each situation is unique and constantly evolves. Our theoretical orientation, the nature of our community and the client's community, our culture and the client's culture, and so many other contexts influence what we see and how we see it -- every ethical decision must take account of these contexts.

3. Awareness of the evolving research and theory in the scientific and professional literature is another important aspect of ethical competence, but the claims and conclusions emerging in the literature should not be passively accepted or reflexively applied no matter how popular, authoritative, or seemingly obvious. We must greet published claims and conclusions with active, careful, informed, persistent, and comprehensive questioning.

4. We believe that the overwhelming majority of psychotherapists and counselors are conscientious, dedicated, caring individuals, committed to high ethical standards. But none of us is infallible. All of us can -- and do -- sometimes make mistakes about
boundary decisions and any other aspect of our work, overlook something important, work from a limited perspective, reach conclusions that are wrong, hold tight to a cherished belief that is misguided. An important part of our work is questioning ourselves, asking "What if I'm wrong about this? Is there something I'm overlooking? Could there be another way of understanding this situation? Could there be a more creative, more effective way of responding?"

5. Many of us find it easier to question the ethics of others -- especially in a difficult and often controversial area like boundaries -- while putting our own beliefs, assumptions, and actions off limits. Questioning someone's ethical decisions and behavior must be a two-way street, and it is crucial to question our own decisions and behavior -- and to open ourselves to questioning by others -- at least as much as we question others. It is a red flag if we spend more time trying to point out the supposed weaknesses, flaws, mistakes, ethical blindness, destructive actions, or error-filled beliefs of a colleague or group of colleagues than we spend questioning and challenging ourselves in positive, effective, and productive ways that awaken us to new perspectives and possibilities.

6. Many of us find it easier and more natural to question ourselves in areas where we are uncertain. It tends to be much harder -- but often much more productive -- to question ourselves about what we are most sure of, what seems beyond doubt or question. Nothing can be placed off-limits for this questioning. We must follow this questioning wherever it leads us, even if we venture into territories that some might view as "politically incorrect" or -- much more difficult for most of us -- "psychologically incorrect" (Pope, Sonne, & Greene, 2006).

7. As psychotherapists, we often encounter ethical dilemmas without clear and easy answers. This is perhaps more true for boundary decisions than for any other area. We may confront overwhelming needs unmatched by adequate resources, conflicting responsibilities that seem impossible to reconcile, frustrating limits to our understanding and interventions, and countless other challenges as we seek to help people who come to us because they are hurting and in need, sometimes because they are desperate and have no where else to turn. We may suddenly need to make dauntingly complex decisions about boundaries "on the spot" as a reaction to a client’s or colleague’s unexpected words or behaviors. There is no legitimate way to avoid these ethical struggles. They are part of our work.

8. Consultation is almost always helpful and sometime crucial. Because we may be blinded by our own issues, consulting with trusted colleagues -- those not involved with the situation -- can strengthen ethical decision-making. Useful perspectives not considered and unrecognized biases may best be revealed by colleagues. Moreover, as we make difficult decisions under stress, we may unintentionally but understandably become more concerned with how the decision affects us -- for example, will it place us at risk for a malpractice suit or licensing complaint, will it alienate a referral sources we depend on, will it cause a managed care company to drop us as a provider. Consultation can help us consider our decision's consequences for all those who will be affected.
Making Decisions Involving Boundaries

In our experience, the following 9 steps are helpful in considering whether a specific boundary crossing is likely to be helpful or harmful, supportive the client and the therapy or disruptive, and in using due care when crossing boundaries.

- Imagine what might be the "best possible outcome" and the "worst possible outcome" from crossing this boundary and from not crossing this boundary. Does this crossing or not crossing seem to involve significant risk of negative consequences, or any real risk of serious harm, in the short- or long term? If harm is a real possibility, are there ways to address it?

- Consider the research and other published literature on this boundary crossing. (If there is none, consider bringing up the topic at the next meeting of your professional association or making a professional contribution in the form of an article.)

- Be familiar with and take into account any guidance regarding this boundary crossing offered by professional guidelines, ethics codes, legislation, case law, and other resources.

- Identify at least one colleague you can trust for honest feedback on boundary crossing questions.

- Pay attention to any uneasy feelings, doubts, or confusions -- try to figure out what's causing them and what implications, if any, they may have for your decisions. A number of psychotherapists who have consulted with us after discovering that a boundary crossing turned sour have commented that they had felt troubled in some way about the path they took across a boundary but that they had failed to take it seriously, had shrugged it off or pushed it out of awareness. For any number of reasons such as fatigue, stress, being in a hurry, not wanting to disappoint a client who wanted to cross that boundary, or failing to appreciate the potential that boundary crossings have to affect clients and the therapy.

- At the start of therapy and as part of informed consent, describe to the client exactly how you work and what kind of psychotherapy you do. If the client appears to feel uncomfortable, explore further and, if warranted, refer to a colleague who may be better suited to this individual.

- Refer to a suitable colleague any client you feel incompetent to treat or who you do not feel you could work with effectively. Reasons to refer range from insufficient training and experience to personal attributes of the client that makes you extremely uncomfortable in a way that makes it hard for you to work effectively.

- Don't overlook the informed consent process for any planned and obvious boundary crossing (e.g., taking a phobic client for a walk in the local mall to window shop).

- Keep careful notes on any planned boundary crossing, describing exactly why, in your clinical judgment, this was (or will be) helpful to the client.
We recommend 3 additional guides that are particularly helpful and accessible. Each because each: (a) is free and available on the internet so that that clinicians, graduate students, interns, supervisors, and others anywhere in the world can access them as long as an internet connection is available, even in the absence of access to a professional library; (b) is free so that those who may be struggling to make ends meet or with limited funds can obtain them without burdening the budget; and (c) and was written by a psychologist elected to serve on the American Psychological Association's Ethics Committee and has experience in working with the ethics code as it impacts the lives of individual psychologists. These guides are Jeff Youngren's "Ethical Decision-making and Dual Relationships" available at [http://kspope.com/dual/younggren.php](http://kspope.com/dual/younggren.php); Janet Sonne's "Nonsexual Multiple Relationships: A Practical Decision-Making Model for Clinicians" at [http://kspope.com/site/multiple-relationships.php](http://kspope.com/site/multiple-relationships.php); and Mike Gottlieb's "Avoiding Exploitive Dual Relationships: A Decision-making Model" available at [http://kspope.com/dual/gottlieb.php](http://kspope.com/dual/gottlieb.php).

### Cognitive Errors and Boundary Crossing Decisions

From time to time we may encounter writings or workshop presentations with a tone of absolute authority and unquestioning certainty, suggesting that some among us are ethically infallible. These authorities come across as above the mental mistakes, personal biases, limited perspectives, convincing rationalizations, and accidental blunders that can trip up the rest of us. But All of us are fallible. We all occasionally find ourselves on the wrong track. As we bring our education, experience, and professional judgment to bear in thinking through a particular boundary crossing possibility in light of the law, the ethical standards, the client's clinical needs, and other relevant contexts, it can be useful to remain aware of how vulnerable we all are to some common cognitive errors. Awareness can help us avoid missteps, some of which may lead to missed opportunities, needless confusion, or serious problems. In this section, we identify seven of the most common cognitive errors that can plague us all.

**Error #1: What happens outside the psychotherapy session has nothing to do with the therapy.**

If we leave the therapy office to attend a special event in the client's life, to teach a class in which our client has unexpectedly enrolled, or to chair a meeting of a PTA task force which our client has just joined, it can be easy to wrongly assume that because these interactions with our client do not occur in the office as part of treatment that they have nothing to do with therapy. We can erroneously believe they exert no possible influence on the therapy and no effect on our relationship with the client.

This error may lead us away from considering how our interactions with clients outside of therapy sessions might influence the client and our work with him or her. That possible influence can range from helpful to problematic, but may also be negligible. Here are some unexpected developments that could complicate the foregoing our scenarios. We might attend the funeral of our client's husband as a natural expression of our caring, respect, and support. The widow, however, may view our presence as a disrespectful intrusion into her outside-of-therapy life. The client-student's note -- “I know you don’t allow make-up exams, but
you know I'm going through a lot of problems right now and am just paralyzed with anxiety, so I'll need to take the test a few weeks from now instead of tomorrow" -- left for us in the school office has implications for the therapeutic alliance no matter how we respond. The PTA task force member blusters into therapy calling us by our first name (when that is not our custom) and pats us on the back while relaying gossip about an affair going on between another task force member and a teacher. The false assumption that everything occurring outside the session is unrelated to the therapy and therapeutic alliance may lead us to omit mention of boundary crossings from our charts and our discussions with clinical supervisors and consultants, compounding the problems.

**Error #2: Crossing a boundary with a therapy client has the same meaning as doing the same thing with someone who is not a client.**

This cognitive error has such a deceptive aura and superficial appeal that we often tend to accept it unquestioningly as obvious...until something happens to wake us up and open our eyes to the fallacy. It can be so easy to reflexively assume that stepping over to help someone take off a coat or put on a coat is, after all, just basic politeness. Or giving someone a ride is obviously just simple courtesy. Or lending money to someone you know and trust is clearly just being helpful. Or dropping by the house or office of someone you like and who likes you to say hello, after calling first to make sure it's convenient, just reflects liking to be with that person. Or meeting with someone for a game of golf, a movie, or a weekend trip to a vacation spot is simply the enjoyment of shared interests.

All these activities are common, natural, and positive when they occur outside the context of psychotherapy, but often have different meanings and effects when they occur in the context of therapy. For example, deciding to take in a movie that both client and therapist were anxious to see might be interpreted by the client -- at the time or later on -- as a romantic date, a mark of ongoing friendship, or something like it. Even far simpler, everyday acts can have unintended effects in the context of the therapist-client relationship. We help a client off with a heavy winter coat, meaning only to be polite and helpful, unaware that the client may experience our stepping close, touching, and removing an article of clothing as unwanted, intrusive, disrespectful, or even frightening and seductive.

No shortcuts in logic can free us from the responsibility of thinking through the nature and implications of what we are doing with our clients. No one-size-fits-all abstractions, theories, or assurances can substitute for considering carefully the individual boundary crossing in context: What effects could this boundary crossing have on this particular client in this particular array of contexts?

This *out of context cognitive fallacy*, which pops up often in research, assessment, and other areas of psychology, can take as many different forms as there are potentially relevant contexts for a given patient. Other contexts that often affect the meaning and effects of boundary crossings include culture, the therapy setting, age and gender of both therapist and client, and other factors relevant to the therapy process itself.
Boundary issues involving cultural traditions and expectations can arise unexpectedly and complicate decisions. A therapist politely refuses a small gift in appreciation for allowing the client to extend the previous session 10 minutes after the hour because she was stuck in traffic and arrived 5 minutes late. Mistakenly thinking that the APA ethics code prohibits accepting any gift from a client as an ethical violation, the therapist declines the gift. What the therapist fails to realize is that for this client, who had recently arrived from India, the refusal of a personal gift is a deep insult. The incident did provide an opportunity to explore feelings and cultural differences that resulted in more understanding between both parties. Not all cultural clashes end so well. It is important to keep in mind that this is not simply a matter of being alert to the client's cultural background and traditions. We must also remain aware of our own cultural, beliefs and how they influence our values, assumptions, perceptions, interpretations, and choices.

Age and gender may also play into how clients interpret the actions and words of their therapists. When an older female therapist says to a young female client, “My, my, don’t you look just lovely today,” it will likely be processed far differently than the same compliment from a young male therapist. Research has found that a significantly greater percentage of male therapists than female therapists believe that certain boundary crossings are ethical and tend to cross those boundaries with their clients (Borys & Pope, 1989).

The therapy setting itself often influences the perception and impact of boundary crossings. Situational contexts set a mood. Both therapist and client are likely to respond differentially to a formal group practice office setting with standard business style furniture as compared to a back room in the therapist’s private home furnished with couches and lounge chairs.

The client's diagnosis or condition and the therapist's theoretical orientation can affect the course of boundary crossings. Koocher and Keith-Spiegel (2008), for example, note that clients diagnosed as suffering from Borderline Personality Disorder (especially if accompanied by hysteroid or paranoid features) or those who develop rapid and intense transferences can be at greater risk with regards to possible disruption or deterioration of the therapy.

Theoretical orientation is our final example of a context that can play a role in decisions to cross or not cross a boundary. Research has underscored that humanistic therapists, for example, tend to have different beliefs than psychodynamic (or cognitive) therapists about the appropriateness of various boundary crossings, and engage in boundary crossings more often (Borys & Pope, 1989). Such differences can be made clear at the onset of therapy.

**Error #3: Our understanding of a boundary crossing is also the client's understanding of the boundary crossing.**

It has probably happened to all of us at one time or another. We say or do something with the best of intentions, certain -- or at least assuming without have given it much thought -- that our
words or actions were just what was needed, or at least what was helpful. And the client surprises us by seeming stunned, hurt, offended, caught off guard, flustered, frightened, repulsed, angry, or confused. We put our arm around a previously untouched client upon learning of the father’s death, and the client goes stiff and becomes distant. We casually mention that our spouse or partner works in the same office as does the client’s mother, and the client says nothing but looks deeply disturbed. As with all aspects of clinical work, it is important to avoid mistaking the way we understand something for the way a client understands it.

Variations of this cognitive error show up in almost countless guises: that our supervisor or consultant will understand a particular boundary crossing the same way we do; that a client's family will understand a boundary crossing in the same way we do; that a licensing board, ethics committee, or malpractice jury will understand a boundary crossing in the same way that we do; that someone reviewing our clinical records about a boundary crossing will have the same understanding of that crossing that we do; and so on.

**Error #4: A boundary crossing that is therapeutic for one client will also be therapeutic for another client.**

This error, which often plays into an understandable tendency to try to identify what "works" for us as therapists and to favor tried-and-true approaches, can surprise us with its effects. A client we've been working with for several months loses her job but needs to continue psychotherapy despite the absence of any suitable low-fee therapy available in the community. Bartering, which is neither clinically contraindicated nor exploitative in this instance, enables her to continue therapy in exchange for providing us with useful services. This works so well that when another client has trouble making ends meet, we immediately offer to barter. However, this client resents working for us, calling us overly-critical and abusive, and referring to us as "boss." The therapeutic relationship quickly deteriorates, the client quits treatment, and a stranger soon shows up at our door to serve us notice of a law suit. Or, a therapist who favors the use of hypnotherapy involving nonsexual touch puts intense pressure on clients, one of whom is terrified about “going over the edge” and another who holds the belief that hypnosis is the work of the devil, and both clients simply stop coming to therapy.

Variations of this error are often subtle, such as a boundary crossing that is right for a client at one stage in therapy will be right for that same client at a later stage in therapy. For example, a financially strapped client substantially improves over the course of several months and lands a good job. The client also experiences newfound self-confidence in her ability to make difficult personal decisions. However, earlier direct and well-meaning advice from her therapist about matters unrelated to therapy are now perceived as insolent.

**Error #5: A boundary crossing is a static, isolated event.**

A boundary crossing can seem so fleeting and trivial that we somehow believe that once it is over and done, we will never see any subsequent effects. We are up all night with a crisis and
barely make it to the office on time, having missed breakfast, for our first client of the day. Reasonably sure that we would not be alive at the end of the first session without a cup of coffee, we stop by the corner convenience story to pick up two cups to go, one for ourselves, the other for the client, just to be polite and so that we won't be sitting there enjoying a hot cup of coffee while the client goes without. It makes so little an impression on us that by midday we've forgotten all about it. The next week the client comes in with 2 cups of pricy coffee from a specialty café and a large assortment of expensive pastries to share during the session, the rest -- because the assortment seems like it would easily feed the population of several adjoining states -- the client will leave in the waiting room for the rest of the day's patients. The same thing happens the following week, and it appears clear that the client is establishing a ritual that will persist throughout the course of psychotherapy. If we try to explain some rule about not bringing in coffee, the client may ask us why we broke our own rule.

The cognitive error of trying to encapsulate events and remove them from the flow of time catches us off guard by coming at us from different directions. We may believe that a client's perceptions, memory, and feelings about a boundary crossing will remain unchanged over the following same days, weeks, months, and years. We may be surprised when our own understanding of a boundary crossing changes over time. We may fail to consider a boundary crossing's potential future complications, unexpected developments, and unintended consequences.

We may believe that the possibility of a boundary crossing will always come into view with some warning, giving us time to think about what we want to do -- and panic when a client who is feeling lonely and discouraged while trying to work through the effects of sexual abuse, greets us at the start of a session by approaching us with a wide embrace and asking for a "big hug." Or a client pulls out a form at the end of a session and asks, “I need you to write me a good letter of recommendation for my job application as the receptionist in this clinic.”

**Error #6: If we ourselves don't see any self-interest, problems, conflicts of interest, unintended consequences, major risks, or potential downsides to crossing a particular boundary, then there aren't any.**

As human beings, we all share an astonishing capacity to deceive ourselves, especially if there is a reason to rationalize. A quick look at cases brought to ethics committees (see, for example, Koocher & Keith-Spiegel, 2008; Pope & Vasquez, 2007) quickly begs a fundamental question: How could highly educated individuals with families and a hard-earned career at stake have committed such acts? What were they thinking!?

Although a few of our colleagues step suddenly, knowingly, and boldly into the realm of blatant disregard for patient safety, ethics, and common sense, many cases reveal a spiraling downward of incremental, tiny, rationalized steps into a quagmire that ultimately astounds even the offending therapists themselves as much as it does the rest of us. This underscores the importance of frequent, honest, and open consultation with trusted colleagues when deciding whether to cross or not cross boundaries. Reluctance to let others know about a potential or actual crossing or to mention it in supervision, peer consultation, or our records may be a red flag
that the crossing could benefit from an open exploration with a colleague who does not have a direct interest in the outcome.

Error #7 Self-disclosure is, per se, always therapeutic because it shows authenticity, transparency, and trust.

When consistent with the client's clinical needs, nature of the psychotherapy, and other factors relevant to a specific situation, self-disclosure can be a valuable resource in therapy. But the idea that self-disclosure is always appropriate, always therapeutic, always wanted by the client, always free of risks or unintended consequences, or always the best option is the source of countless boundary mistakes.

A therapy client confided to us that before she finally terminated the relationship she would count the minutes that the therapist spent “rattling on about himself.” At $2 a minute she felt she should get a refund of $30 after every session. In another case, the client complained that the therapist was not paying attention to her distress about her husband forgetting her birthday. The therapist apologized and then informed the client that her granddaughter had drowned in the family pool the previous day. The embarrassed and confused client left quickly, unprepared for such a tragic disclosure. The therapist would have served her clients’ needs better had she taken more time to grieve.

How can we identify those self-disclosures that are most likely therapeutic, and avoid those most likely to be unhelpful, unwanted, mistimed, or disruptive? These questions may be helpful in thinking through possible self-disclosures. First, is it consistent with the client's clinical needs and the therapy goals? Second, is it consistent with the kind of therapy you are providing and your theoretical orientation? Third, does it mainly reflect or express your own personal needs (to talk about yourself, to bring the focus to yourself)? Fourth, what is your purpose in self-disclosing at this particular time? Fifth, what is your assessment of the possible risks, costs, or downsides, if any, of self-disclosure with this client in this situation at this time? Sixth, does self-disclosure -- or disclosing this particular content or level of detail -- represent a significant departure from your usual practice? If so, why the change? Seventh, will you hesitate to discuss this disclosure with your supervisor or consultant or document it in the client's record? If you would hesitate, what are the reasons? (We do not publish extended lists of references; instead, please direct the reader to Recommended Readings at the end of the article)

What Can We Do When Boundary Crossings Go Wrong?

Some boundary crossings catch us off guard -- suddenly we encounter a client outside of therapy, say, at a friend's small dinner party, or on the street when we have just had a minor fender-bender with a client. Flustered and with no time to think, we make a very human blunder. Other boundary crossings may be virtually inevitable or inescapable. In a very small and
geographically remote town, we may be -- of necessity -- in more than one relationship with our therapy clients, and some of these relationships may cause boundary crossings that undermine the therapy. Still other boundary crossings, despite the best of intentions, the most careful planning, and the most skillful intervention, may go wrong -- therapy veers off course, the relationship unravels, growth and progress stall.

The signs of trouble may be sudden and unmistakable -- the client criticizes us for crossing the boundary or for some consequence of the crossing, abruptly terminates, or perhaps even files a formal complaint. But the signs may also be more subtle, and it may not even be clear whether the boundary crossing or something else is the cause -- the client begins missing sessions or not paying on time, the rapport between us and the client starts to erode, or there may be nothing specific we can point to but somehow things seem a little "off."

Whether the signs of trouble with a boundary crossing are blatant or vague, if we start to suspect that we may have made a mistake, not handled the situation well, or need to address the effects of a boundary crossing, each of us faces a significant question: What do I do now?

Our work with therapists in this area lead us to believe that the following 9 steps are helpful when a boundary crossing causes -- or seems to be leading toward -- serious problems.

- Continue to monitor the situation carefully, even though paying attention to it may be uncomfortable. Few of us enjoy thinking of the work we do -- psychotherapy -- not going well, perhaps causing harm, however unintentionally. We may have a hard time realizing that we have made a mistake, perhaps a big one, and assuming responsibility for our error. However, in our experience, denial and avoidance are almost always powerful resources for turning an emerging problem into a disaster.

- Be open and nondefensive, even though this be hard for any of us at times. As we consider how our crossing a boundary with a client had negative results, we may be tempted to minimize the relationship between crossing the boundary and the negative impact. We may experience an impulse to downplay or trivialize the impact. We may find ourselves wanting to attribute the negative impact not to the boundary crossing but rather to the client's condition (which many of us at this point decide is almost certainly "borderline"), to the client faking or exaggerating, to the client's life circumstances -- to anything except our crossing a boundary with the client.

- Talk over the situation with an experienced colleague who can provide honest feedback and thoughtful consultation. Even when we can be honest and nondefensive with ourselves, it can be hard to open up to a respected colleague about our work not going well, about the possibility that we may have made a mistake that ended up hurting a client. Will our colleague think less of us? Be critical? Question our competence and judgment? What sorts of feelings do we experience when we think of disclosing our blunders or instances in which we need help because we are not sure what to do? Do we feel anxious, embarrassed, ashamed, guilty, inadequate, panicked, or even afraid? Does some part of us feel -- if we're completely honest with ourselves -- like crying or running and hiding? Consultation about boundary crossings that have turned disruptive and
perhaps harmful is likely to be helpful only to the extent that we can be honest with the consultant.

- Listen carefully to the client. We may make all sorts of assumptions about how the client is reacting to the boundary crossing or the crossing's negative consequence, but these may be completely off base. Too often, we may find ourselves starting to say something along the lines of "I know just how you feel," or "I know you must just feel terrible [or angry, betrayed, etc.]," when in fact we are only guessing instead of asking.

- Try to see the matter from the client's point of view. A client may experience a boundary crossing in a way that represents the opposite of what we intended, of what we anticipated, and of what the client anticipated. Empathizing with the client's experience may be particularly difficult if the client is angry and accusing, has withdrawn from therapy, or has decompensated.

- If the situation involves a formal complaint, consider the special steps described in the chapter "Responding to Ethics, Licensing, or Malpractice Complaints" (Pope & Vasquez, 2007) and the chapters "Enforcement of Ethical Conduct" and "Mental Health Professionals in the Legal System" (Koocher & Keith-Spiegel, 2008).

- Keep adequate, honest, and accurate records of this situation as it evolves. Just as we may find it difficult to disclose what happened and its implications to a respected colleague, it may be hard to make a written record of the situation, especially one that may ultimately be seen by the client and others. Aside from our responsibility to maintain adequate clinical records, therapists often find it remarkably useful to chart the events with as much clarity and honesty as possible. It helps in making sense of the situation and in finding ways to respond positively and constructively.

- If you believe that you made a mistake, however well intentioned, consider apologizing. This topic is so complex and so often stirs up strong emotions that we decided it deserved its own major section, which follows.

### What About Apologizing?

There appears to be wide-spread fear that to apologize to clients for our mistakes in handling boundaries is to take unnecessary and unwise risks by admitting guilt. Apologizing can make us feel vulnerable. What will happen now? Will the apology be accepted or will it just make things worse and enrage the individual? Will it be taken as disingenuous or inadequate? Will the client see us weak or incompetent? Will the apology come back to haunt us as admission of guilt in a formal licensing complaint or law suit?

If the boundary crossing was inadvertent or unintended, if we acted in what we thought was the client's best interests, we may feel like we owe no apology. And if the client is angry at us, fails to realize that we have done far more good than harm, seems to be going overboard in reacting to what was a relatively minor slip on our part, has not been as understanding as we'd like, or is complaining in an accusatory, insistent, loud, repetitive, or whiny way, we may not
believe that such a person deserves an apology, and wish the client would just shut up about it and move on or drop out of therapy and go bother some other practitioner.

It is also true that, at least for some of us, apologies rarely come easy, especially if the matter is serious, may lead ultimately to a formal complaint, and we cannot be certain about the consequences of either apologizing or declining to apologize:

It seems to be part of the human condition that it is difficult for many of us to admit mistakes, especially when they have hurt someone, and to apologize. It can be much harder when it will go on the record, may be influential in sustaining the validity of a complaint, and it offered to someone who is angry -- perhaps enraged -- at you. There may also be friends and colleagues who advise you to despise the person who filed a complaint against you and to fight the complaint.... There can be strong reasons favoring and opposing [apologizing in a specific situation], and it is impossible to foresee all the consequences and implications of taking or not taking this path. (Pope & Vasquez, 2007, pp. 106-107)

Research suggests that an apology can help healing the effects of purposeful or inadvertent professional mistakes (e.g., Robbennolt, 2003). Over half the states have passed "I'm sorry" laws to encourage doctors both to promptly and fully inform patients of errors and to apologize when warranted, and other states are considering them (Henry, 2007). When the Veteran’s Affairs Medical Center in Lexington, Kentucky adopted a policy of admitting mistakes, and apologizing when appropriate, malpractice costs and settlements dropped significantly (Kraman & Hamm, 1999).

A partial, qualified apology may be worse than no apology at all (Robbennolt, 2003). Apologies should be clear, direct, personal, and sincere. Unfortunately, the art of the "non-apology apology" has gained widespread practice, and there are no shortage of "apologies" that disappear into the passive voice ("mistakes were made and they are regretted"), smother what happened in generalities and possibilities ("I regret any substandard care that might have occurred"), and rely on shifting the responsibility to the patient for reacting in a certain way ("If any patients took offense when I referred to them by using a racial epithet that some laws consider "hate speech," I am truly sorry and hope they will accept my apology so that we can move on"). Apologies can dodge responsibility for choosing to do something wrong by acting as if it were question of judgment as in trying to judge what wine goes best with a meal ("No one could be more apologetic than I am, so I hope that you will agree that no one is perfect, will remember that we psychologists believe that people can change and deserve a second chance, will keep in mind the power of forgiveness, and will forgive my error in judgment, my very human mistake in spending everyone's pension funds on some European ski trips that I needed to deal with the stress of my job as CEO of this mental health center, in borrowing the identities of many of you last month to obtain loans to cover payments for some wonderful houses I bought in Switzerland"), and the other strategies for making apparent apologies (see "Language, Apologies, and Critical Thinking" on pages 27-33 of Pope & Vasquez [2007]).

We are aware of instances where ethics complaints were considered but never pressed
because the psychotherapist apologized to the client for whatever it was that was of concern and
did it right. Every one of us has experienced the healing power of the words, “I’m really
sorry.” Apologizing is a personal, intimate act. Deciding whether or not to apologize requires
the same care as any clinical and ethical judgment, taking the client, the context, and the nature
of the boundary crossing itself into account.

Conclusion

Nonsexual boundary crossings can enrich therapy, serve the treatment plan, and
strengthen the therapist-client working relationship. They can also undermine the therapy,
sever the therapist-patient alliance, and cause immediate or long-term harm to the
client. Choices about whether to cross a boundary confront us daily, are often subtle and
complex, and can sometimes influence whether therapy progresses, stalls, or ends. We put
ourselves in the best position to make sound decisions when we develop an approach to
boundary crossings that is grounded in our general approach to ethics; stay abreast of the
evolving legislation and case law, ethical standards, research, theory, and practice guidelines;
take into account the relevant contexts for each client; engage in critical thinking that avoids the
common cognitive errors to step away from our clinical responsibilities, avoid personal
responsibility for our decisions, and rationalize our choices and behavior; and, when we make a
mistake or suspect that our boundary decisions have led to trouble, use all available resources to
figure out the best course of action to respond to the problem.

And a final reminder of what we all know but sometimes forget: None of us needs to
think through these questions on our own. We are part of a large and diverse community of
skilled professionals who try to make the best decisions possible to help our clients. Our
decisions about boundaries -- and both our professional and our personal lives -- gain from the
perspectives, strengths, empathy, constructive questioning, support, and caring from each other.

Selected References & Recommended Readings

study of psychologists, psychiatrists, and social workers. Professional Psychology: Research and


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