In Celebration of Dual Relationships

How Prohibition of Non-Sexual Dual Relationships Increases the Chance of Exploitation and Harm

Ofer Zur[1]

1. Real life

Jack and I have played basketball for several years in our local recreational league. His wife, Janet, and I chaperone our children on field trips together and are on the same educational committee. When they called me seeking help to save their marriage, I delivered my sermon about dual relationships, objectivity, and ethical guidelines. In short, I was not the man for the job. I had taught ethics, research and clinical courses at the graduate and post-graduate level for over a decade, and my sermon was polished and substantiated with quotes, references and court cases. To my surprise Jack and Janet were outraged rather than being understanding. "We have known you for a long time," they said, "we know your values and how you treat your wife, your children and your friends. We know of several marriages you have helped put on the right path. We choose you because we know you and because you know us well. Besides, we have already tried several other counselors to no avail, we are on the brink of divorce and do not have the time to tell our stories once again to another stranger."

Moving to a serene, small town in the Northern California wine country was significantly less serene than I had anticipated, regarding my private practice. Psychodynamically oriented and cognitively trained, I had immense difficulty dealing with the lack of customary professional boundaries between my clients and myself. It was a shocking realization that people were choosing me as their therapist because they knew me and I knew them. Everything I had learned from graduate school, my supervisors or had absorbed from the professional literature led me to believe this was perilous.

Alarmed, I consulted with attorneys, supervisors, experts on ethics, and experienced therapists regarding my dilemma. How, I asked them, could I work with people who are part of my community? We discussed the ethical, legal, and clinical implications of such relationships on transference, countertransference, therapeutic alliance, boundaries, conflict of interest, objectivity, standard of care, power, freedom of choice, etc. We also analyzed in detail the potential clinical risks and benefits of entering into therapy with these people. The near consensus seemed to be that what I was doing was clinically, legally, and ethically inappropriate, and even dangerous. Though all my clients were fully informed about the complexities of dual relationships through my office policies, verbal explanations and through receiving an actual copy of the APA Ethics Code, and I was neither engaged in sexual or business interactions with them, nor exploited or harmed them in any way, I was warned that I was walking into a mine field.

Despairingly, I started looking for a job in my former profession of oceanography and deep sea diving. To my dismay I found no ads in the local paper stating: "A local winery is looking for an experienced deep sea diver."

2. Playing Russian Roulette with the soul.

Some clients' systematic search for a therapist-consultant is as sensible as it is rare. One client of mine, a physician, spent a couple of years observing me, reading my publications, meeting my wife and children and following up closely on cases he referred to me. All this, admittedly, for the purpose of checking me out as a potential therapist for himself. When people contact me through the Yellow Pages or from the list provided by my psychological association, I am shocked at the callousness of the lottery-type approach they are taking in the care of their psyches. In fact they are playing Russian roulette with their souls.

3. The Original Prohibition

"Dual relationship" refers to any situation where multiple roles exist between a therapist and a client. Besides having sex with a client, other examples of dual relationships are, engaging in therapy with a student, friend, or business associate.

The original prohibition on dual relationships in therapy emerged from two sources. Professional, federal, and state regulatory agencies developed the prohibition in an attempt to prevent therapists from exploiting and harming clients. Traditional psychoanalysis developed such prohibition for theoretical-analytic and clinical-transferential reasons.

Issues of exploitation in general, and sexual or business exploitation in particular, are appropriately at the forefront of consumer advocates' agendas. The valid concern is that helping professionals, especially psychotherapists, can easily exploit their clients by using their positions of power for personal gain. Hence, the effort to curtail exploitation and to protect consumers from harm is indeed essential.

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4. Going Too Far in the Right Direction: The Demonization of Dual Relationship

Professional organizations, consumer protection agencies, and legislators use the therapist-client sexual prohibition and the concern with exploitation as the basis for all their protective policies and guidelines. The original intent of the regulatory agencies to protect the welfare of clients by putting forth a straightforward ban on sexual relationships between therapists and clients (Ebert, 1997) has become a massively broad prohibition of all dual relationships. As a result, the absolute avoidance of dual relationships is raised as a magical amulet against any and all possible harm to patients involved in therapeutic treatment. Consequently, the term "dual relationship" has been used interchangeably in the professional literature with "exploitation," "harm," "abuse," "damage," and "sexual abuse."

As we are repeatedly reminded, the primary rationale for the avoid-all-dual-relationships argument is that therapists may misuse their power, and influence and exploit clients for their own benefit and to the clients' detriment. A Power issue is certainly a valid concern. But is it reasonable to view the dual relationship as the sole source of exploitative interaction? Such unilateral responsibility can only be bestowed through a belief in the domino theory or snowball effect of dual relationships; one thing inevitably leads to another. An initially innocent hug will inevitably progress to sexual intercourse and a gift will inevitably lead to a business relationship.

Kenneth Pope, a leading expert in ethical matters, makes a claim that has become a strict standard of therapeutic ethics and law: " . . . non-sexual dual relationships, while unethical and harmful per se, foster sexual dual relationships" (1990, p. 688). Simon (1991) agrees that "The boundary violation precursors of therapist-patient sex can be as psychologically damaging as the actual sexual involvement itself" (p. 614). These chilling words epitomize the notion that by avoiding any semblance of dual relationships we necessarily avoid all forms of exploitation and harm.

To assert that self disclosure, a hug, a home visit, or accepting a gift is likely to lead to sex is like saying doctors' visits cause death because most people see a doctor before they die. One of the few master therapists who brings refreshing critical thinking to the field of ethics is Dr. Arnold Lazarus, the founder of Multimodal therapy who calls this thinking "an extreme form of syllogistic reasoning." (1994, p. 257). Sequential statistical relationships, as my undergraduate research professor emphasized, cannot simply be translated to causal ones.

5. When fear overrides clinical judgment

The tyrannical fear of lawsuits, combined with nineteenth century analytical dogma and many hyper-vigilant regulatory and consumer protection agencies, has created much dread and trepidation for therapists. As a result, courses and publications on risk management have become big business. "Risk Management" may sound like practical advice, but often, it is a misnomer for a practice where fear and attorneys determine the course of therapy.

6. If Dual Relationships aren't Unethical, why isn't the Prohibition Dead?

Due to the concern of rural and military therapists that dual relationships are unavoidable in such small and interwoven communities, most professional associations, among them the American Psychological Association (APA) have revised their ethical guidelines regarding dual relationships. Discarding the traditional strict prohibition on dual relationships.

The revised APA Ethical Guidelines of 1992, in section 1.17 is simply states:

In many communities and situations, it may not be feasible or reasonable for psychologists to avoid social or other nonprofessional contacts with persons such as patients . . .A psychologist refrains from entering into or promising another personal, scientific, professional, financial, or other relationship with such persons if it appears likely that such a relationship reasonably might impair the psychologist's objectivity or otherwise interfere with the psychologist's effectively performing his or her functions as a psychologist, or might harm or exploit the other party.

To most readers it will come as a surprise that the 1992 Revised Ethics Code does not consider dual relationships unethical. However, the changes in ethics codes have not put a dent in the professional and public opinions regarding the evils of dual relationship. Even today, this erroneous prohibition is assumed and implemented by most professional organizations, licensing boards, ethical committees and the courts.

Even the more relaxed 1992 version has been challenged for it's constitutionality, surprisingly, by Ebert (1997), a psychologist, attorney and former Chairman of the California Board of Psychology. He challenges the constitutionality of the prohibition due to the vagueness and the excessive breadth of the prohibition and how it may violate the constitutional right for privacy and association.

7. On being the flasher in Alaska

Flying with a client who has a fear of flying is a mandated exposure-intervention to the behavioral therapist, but is a boundary violation to the psychoanalyst and most ethicists. Seeing a wife and husband in joint and individual therapy simultaneously can be part of well-articulated systems based therapy, but constitutes a severe boundary crossing to the psychodynamic therapist. A walk on a trail might be part of a strategically planned intervention for the humanistically based therapist, but a transgression to the interpersonal practitioner.

Staying in the office regardless of the presented problem may seem right to analysts, ethicists or attorneys, but may not help those who suffer from agoraphobia, social phobia or fear of flying. They require leaving the office and going to open places,

mixing with the crowd, or getting on an airplane. Practicing risk management by staying in the office cold, aloof and detached is like the story about the flasher in Alaska where it is too cold to flash, so he just describes it. It neither works for the flasher nor for our clients.

8. In Praise of dual relationships

Familiarity and Therapy: Unlike the common myth that familiarity is an obstacle to therapy I have found it to be extremely helpful. Relying on a neurotic or psychotic clients' distorted reports is futile and a set up for failure. Also, clients' familiarity with my spiritual beliefs and personal ethics help them trust me more readily and realistically. Familiarity often shortens the length of therapy and increases it's effectiveness.

Transference and Dual Relationships: There is an unsubstantiated myth that familiarity and dual relationships interfere with the transference analysis. Transference occurs anywhere and anytime not only when facing a "blank wall." Whether or not I know the people or they know me outside of therapy, transference and counter-transference take place and if the clinician is so inclined the analysis can take place.

Isolation, Power, Duality and Exploitation: While privacy is often an important component in increasing psychotherapeutic effectiveness, it can also be a double-edged sword when it is used as an excuse for isolation. The privacy-secrecy argument also has been used to justify many therapists' attempts to hide, assert power inappropriately or exploit. Sexual exploitation is less likely to occur if the therapist is also working with the spouse of a client, or has an outside connection to the family, perhaps through church. In other words, sexual and other forms of exploitation are less likely to occur in therapy if dual relationships exist. Similarly, isolating clients in therapy gives the therapist undue power and an easier opportunity to exploit clients.

Isolation and the "Resistance" Excuse: In the isolation of the office without dual relationships, therapists can easily blame the clients for their own ineffectiveness by using the famous "resistance" charge. The prohibition of dual relationships enables incompetent therapists to be unaccountable for long periods of time while they charge, exploit and harm clients by continuing therapy even when clients do not get better. So, we not only falsely charge them for services rendered, but, far more detrimental, we give them the sense that they are permanently and hopelessly damaged.

Exploiting Therapists Will Exploit: The problem of exploitation and harm lies not within the dual relationship, but in the therapist's propensity to exploit and harm. Therapists who tend to exploit will exploit clients with or without dual relationships. The Ethics Code must ban harm and exploitation not dual relationships.

Dual Relationships in a Healthy Society: In a healthy society, unlike our modern culture, people celebrate their reliance on each other. The more multiple the relationships, the richer and more profound the individual and cultural experience. The witch doctor, the wise elder, and the practical neighbor all contribute advice, guidance and physical and spiritual support. In ministering to the needs of the members of the community, therefore, the healers, rabbis, priests, or therapists don't shun dual relationships, but rather rely on them for the insight and intimate knowledge that such relationships provide.

On Power Differential: One must remember that neither dual relationships nor any relationship with a differential of power (i.e., parent-child, teacher-student) are inherently exploitative. While unpleasant to contemplate, it is altogether possible that many therapists cling to the false ideals of the segregated therapy session because it increases their professional status, imbuing them with undue power, which can all too easily be translated into exploitation.

Dual Relationships are Normal and Complex: More than half of America's businesses are family run, in which people experience the complexities of dual relationships, balancing blood and money. Similarly, working professionally with people I know outside of the office adds richness and unavoidable complexities to our lives.

9. Conclusion:

The ban and demonization of dual relationships has come from an attempt to protect the public from exploiting therapists. Regretfully, it has emerged as a simplistic solution to a wide and complex problem. Even worse, the ban on dual relationships and the isolation it imposes on the therapeutic encounter tends to increase the chance of exploitation and decrease the effectiveness of treatment. It enables incompetent therapists, to wield their power without witnesses and accountability. In addition it buys into the general cultural trend towards isolation and disconnection. We have been frightened into accepting the ban, but now it is time to think critically, be courageous and dare to be known by our clients. If we dare to cultivate multiple, non-sexual and non- exploitive relationships with our clients when appropriate, we can be better, more effective therapists.

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Guidelines For Non-Sexual Dual Relationships and Boundaries in Psychotherapy

Definition:

Dual relationships in psychotherapy refers to any situation where multiple roles exist between a therapist and a client. Examples of dual relationships are when the client is also a student, friend, family member, employee or business associate of the therapist. This page focuses only on non-sexual dual relationships.

Non-sexual dual relationships in psychotherapy: Eleven Key Points

Non-sexual dual relationships are not necessarily unethical or illegal. Only sexual dual relationships with current clients are always unethical and illegal.

Non-sexual dual relationships do not necessarily lead to exploitation, sex, or harm. The opposite is often true. Dual relationships are more likely to prevent exploitation and sex rather than lead to it.

Almost all ethical guidelines do not mandate a blanket avoidance of dual relationships. All guidelines do prohibit exploitation and harm of clients.

Dual relationships may not be avoidable in rural communities, the military and among small communities, such as churches, gays, lesbians, the deaf, NA, AA, people with AIDS, Hispanic, African American and many other minorities.

The prohibition of dual relationships may be unconstitutional as it may infringe on people's constitutional rights of freedom of association.

Exploitative therapists will exploit with or without dual relationships.

Avoiding all dual relationships keeps therapists in unrealistic and inappropriate power positions, increasing the likelihood of exploitation.

The prohibition of dual relationships leads to increased isolation, which has several serious ramifications:

Isolation increases the chance of exploitation of clients by therapists.

Isolation in therapy reduces effectiveness because client's difficulties, which were often caused by familial/childhood isolation, often cannot be healed by further therapeutic isolation.

Isolation forces the therapist to rely on the client's report as the main source of knowledge. Therapeutic effectiveness can be diminished by excluding collateral information and by exclusive reliance on a client's subjective stories.

Not all therapeutic approaches disparage dual relationships. The most practiced and empirically based approaches, such as Behavioral, Humanistic, Cognitive, Family Systems, Group and Existential therapy at times see dual relationships as an important and integral part of the treatment plan.

Most graduate and post-graduate education not only instills fear of licensing agencies and lawsuits, but also delivers inadequate instruction in personal integrity, individual ethics, and how to navigate the complex issues of boundaries, duality, and intimacy in therapy.

Introducing dual relationships may alter the power differential between therapists and clients in a manner, which can facilitate better health and healing.

Boundary Crossings and Boundary Violations in psychotherapy: Key Points

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.

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.

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.

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.

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.

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.

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.

As with dual relationships, what constitutes harmful boundary violations according to one theoretical orientation may be considered helpful boundary crossings according to another orientation.

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.

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.

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.

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.

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.

Boundary crossings with certain clients, such as those with borderline personality disorders are not usually recommended. Effective therapy with borderline clients, for example, often requires a clearly structured and well-defined therapeutic environment

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.

Guidelines for Non-Sexual Dual Relationship in Psychotherapy

Treatment plans:

Develop a clear treatment plan for clinical interventions which are based on client's problems, needs, personality, situation, environment and culture.

Intervene with your clients according to their needs, as outlined in each of their treatment plans, and not according to any graduate school professor's or supervisor's dogma or even your own beloved theoretical orientation.

Some treatment plans may necessitate dual relationships however, in other situations dual relationships should be ruled out. Make sure you know the difference.

If planning on entering a dual relationship you must take into consideration the welfare of the client, effectiveness of treatment, avoidance of harm and exploitation, conflict of interest, and the impairment of clinical judgment. These are the paramount and appropriate concerns.

Do not let fear of lawsuits, licensing boards or attorneys determine your treatment plans or clinical interventions. Do not let dogmatic thinking affect your critical thinking. Act with competence and integrity while minimizing risk by following these guidelines.

Incorporate dual relationships into your treatment plans only when they are not likely to impair your clinical judgment, or create a conflict of interest.

Do not enter into sexual relations with a client because it is likely to impair your judgment and nullify your clinical effectiveness.

Remember that treatment planning is an essential and irreplaceable part of your clinical records and your first line of defense.

Consult with clinical, ethical or legal experts in very complex cases and document the consultations well.

Prior to and during therapy which includes dual relationships:

Study the clinical, ethical, legal and spiritual complexities and potential ramifications of entering into dual relationships.

Attend to and be aware of your own needs through personal therapy, consultations with colleagues, supervision or self-analysis. Awareness of your own conscious and unconscious needs and biases helps avoid cluttering the dual relationship.

Before entering into complex dual relationships, consult with well-informed and non-dogmatic peers, consultants, and supervisors.

When you consult with attorneys, ethics experts and other non-clinical consultants make sure that you use the information to educate and inform yourself rather than as clinical guidelines. Separate knowledge of law and ethics from care, integrity, decency and above all effectiveness. Remember you are paid to help and heal, not to protect yourself.

Discuss with your clients the complexity, richness, potential benefits, drawbacks and likely risks that may arise due to dual relationships.

Make sure that your office policies include the risks and benefits of dual relationships and that they are fully explained, read and signed by your clients before you implement them.

Make sure your clinical records document clearly all consultations, substantiations of your conclusion, potential risks and benefits of intervention, theoretical and empirical support of your conclusion, when available, and the discussion of these issues with your client.

Clinical integrity and effectiveness:

Remember you are setting an example. Model civility, integrity, emotionality, humanity, courage, and, when appropriate, duality.

As a role model, telling your own stories can be an important part of therapy. Make sure that the stories are told in order to help the client and not to satisfy your own needs.

Remember that you are being paid to provide help. At the heart of all ethical guidelines is the mandate that you act on your clients' behalf and avoid harm. That means you must do what is helpful, including dual relationships when appropriate.

Answer clients' basic and legitimate questions about your values and beliefs, including your thoughts on dual relationships.

Continue to keep excellent written records throughout treatment. Keep records of all your clinical interventions, including dual relationships, additional consultations and your own and your clients assessment of treatment and its progress.

Evaluate and update your approach, attitudes, treatment plans and above all effectiveness regularly.

If you find yourself in a dual relationship which either is not benefiting the client or is causing distress and harm, or has unexpectedly brought about conflict of interest, consult and, if necessary, stop or ease out of the dual relationship in a way that preserves the client's welfare in the best possible way.

Out-of-Office Experience:

When Crossing Office Boundaries and Engaging in Dual Relationships are Clinically Beneficial and Ethically Sound

Ofer Zur

Introduction

Conducting therapy outside the office, leaving the office with a client, and having non-therapeutic contact with clients out of the office have been frowned upon for legal (Bennett Bricklin, & VandeCreek, 1994), ethical (Gottlieb, 1993, Pope & Vasquez, 1991) and clinical (Borys & Pope 19899, Simon, 1991) reasons. They have been called boundary violations, boundary crossings, and boundary transgressions (Gutheil & Gabbard 1993; Keith-Spieger & Koocher, 1985).

Out-of-office experiences, whether part of a treatment plan or not, have also been placed high on the "slippery slope" list of items (Gutheil & Gabbard, 1993; Simon, 1991; Strasburger, Jorgenson, & Sutherland, 1992). The term "slippery slope" alludes to a snowball dynamic and has been described as follows: " . . . the crossing of one boundary without obvious catastrophic results (making) it easier to cross the next boundary." (Gabbard, 1994, p. 284). Kenneth Pope, a leading expert in ethical matters, makes a claim that not only supports the "slippery slope" idea but has become a strict standard of therapeutic ethics and law: " . . . non-sexual dual relationships, while not unethical and harmful per se, foster sexual dual relationships." (1990, p.688). Following this line of thinking, the conclusion is, "Obviously, the best advice to therapists is not to start (down) the slippery slope, and to avoid boundary violations or dual relationships with patients." (Strasburger, et al., 1992 p. 547-548).

Interacting with clients out of the office has traditionally been placed under the broad umbrella of dual relationships. A dual relationship in psychotherapy occurs when the therapist, in addition to his or her therapeutic role, is in another relationship with his or her patient. Since the early nineties, the ethical codes of the American Psychological Association (APA) (1992) and all other major professional associations no longer impose a strict and uniform ban on dual relationships. Instead, the changed codes acknowledge that dual relationships may not always be avoidable or unethical. While the absolute ban has been lifted, the belief in the prohibition is still prevalent (Faulkner & Faulkner, 1997; Gutheil & Gabbard, 1993; Strasburger, et al., 1992). The revised code of ethics calls on therapists to avoid dual relationships only, " . . . if it appears likely that such a relationship reasonably might impair the psychologist's objectivity or otherwise interfere with the psychologist's effectively performing his or her function as a psychologist, or might harm or exploit the other party." (APA, 1992, p.1601).

In response to an increase in client complaints and litigation, insurance companies, ethics committees, licensing boards, and attorneys have been advising therapists to "practice defensively" and to employ "risk management techniques". (Bennett et al., 1994; Keith-Spiegle & Koocher, 1985; Pope & Vasquez, 1991; Strasburger, et al, 1992). Simon (1991) induces even more dread with his, often quoted, chilling, and ludicrous statement that, "The boundary violation precursors of therapist-patient sex can be as psychologically damaging as the actual sexual involvement itself." (p. 614). As a result, therapists are acting out of fear of lawsuits and boards sanctions rather than according to what is effective and helpful. Consequently, clinical judgment and treatment are often compromised (Ebert 1997, Lazarus, 1994a, b, 1998, Tomm, 1993; Williams, 1997; Zur, 2000a, b).

Consumer advocates advise against leaving the office and against dual relationships in an attempt to protect the public from exploiting therapists (Barnett, J. E., 1996; Bennett et al. 1994). This argument is primarily based on psychoanalytic theory, which asserts that all clinical contacts must be strictly confined to the office. According to this theory, leaving the office interferes with the transference analysis, the hallmark of analytic work. While only a limited segment of therapists practice psychoanalysis, all the rest of the therapeutic community is unfairly held to this standard (Williams, 1997). Holding therapists to such standards, which they neither believe in nor practice, is one of the biggest impediments in the field of psychotherapy (Lazarus, 1994a, b; Zur, 2000a).

This paper attempts to shed a new light on the rarely discussed issue of deliberate and strategic crossing of the office boundaries. It argues that leaving the office may not only be ethical and effective but may actually be clinically mandated in certain situations. This paper describes how leaving the office can be consistent with behavioral, systems, humanistic, cognitive-behavioral, multimodal, and other non-analytic orientations. The paper discusses three types of out-of-office experiences. The first type is where the out-of-office experience is part of a thought-out, carefully constructed, research-based, treatment plan. The second is where the out-of-office experience is geared to enhance therapeutic effectiveness. The third type is comprised of encounters that naturally occur as part of normal living in one's community. While the first two types do not constitute dual relationships, the third one does.

Out-of-office experiences as part of a treatment plan

By the time he sought my services, John was on the brink of bankruptcy; his business was suffering gravely due to his debilitating fear of flying. I outlined behavioral, biological, and psychodynamic treatment options for him. His sense of urgency induced him to start with systematic desensitization. Following the standard behavioral protocol, I introduced him to gradual, progressive exposures to anxiety-eliciting images culminating with an in-vivo experience of flying. To carry out this last step, he booked us on a round trip flight from San Francisco to Los Angeles with an hour layover in LA. He was able to fly thereafter and salvaged his business.

Jean was anorexic and bulimic. She had undergone both cognitive and psychodynamic therapy without success. Wanting to try a different approach, we developed a family-systems and behavior-based treatment plan which included individual lunches and family dinners in which I participated. We discussed privacy concerns and ways to deal with the possibility of friends or colleagues approaching us during our restaurant meetings. Jean attributed the success of our therapy to the multiple approaches and the flexibility of the in and out-of-office experiences.

I saw Mary and her husband over the course of a year for marital therapy. During therapy, Mary revealed a long history of abusive relationships with men, which included sexual molestation at a young age and, more recently, sex with a therapist. As we had achieved our original treatment goal of strengthening the marital unit, Mary requested to shift to individual therapy, aimed at dealing with the abuse issues. She set some clear conditions for her individual work with me. My suggestions for her to continue therapy with a female therapist were rejected. For obvious reasons, she would not meet with me, initially, alone in my office; therefore, we agreed to meet at a coffeehouse where she would feel safe due to its public nature. As with Jean, we discussed the potential ramifications of meeting in a public place. As with Jean, significant progress was achieved within a few months and we were able to shift therapy to the office.

Max was a young mechanic with unusual Schizotypal features characterized by connecting with machines rather than human beings. He came to see me at the insistence of his mother who was concerned with his increased isolation and suicidality. He clearly did not like my office. Five minutes into the first session, on his way to the door, he offered to show me his newly restored car. I had to choose between stopping treatment before it had even started and accepting his offer. For the next couple of years, he would enter my waiting room punctually and from there we would depart to various destinations. As he welded and tinkered, I learned about his relationships with his parents, and between carburetors and distributor caps I found insights into his distrust of people and love of machines. As our "under the hood" therapy progressed, he gradually came to trust me, and a few others. He even developed his first (arm's-length) relationship with a woman. Since that first day, he has never entered my office.

Jerry has suffered from Schizophrenia since childhood. Over the many years that we have been working together, at his request, we have spent many of our sessions walking and talking and marveling at the natural beauty of a nearby trail. In my office, he is often withdrawn, anxious, and distracted, while on the trail he is much more open and relaxed.

Twenty years after Jill's daughter died in a car crash, I accompanied her, at her request, on her very first visit to her daughter's grave. The psychiatrist who Jill had seen immediately after the crash gave her Valium, to which she became addicted. Her second therapist dismissed her request to be accompanied to the grave as "resistance" and "acting out of the transference." Clearly neither was helpful in her hour of need and both proved to be harmful as they interfered with her grieving process.

Spending several years with John in psychoanalysis, exclusively in the office, immersed in transference interpretation or in an existential exploration of the meaning of his fear of flying would not have helped John avoid bankruptcy. Since Jean's eating disorder had not been helped by a couple of legitimate approaches, it was time to try something else. Refusing Mary's coffeehouse arrangement might have been good risk management practice, but would also have constituted abandonment - an ethical violation. Max would not meet anywhere but "under the hood". There was no choice in the matter if I wanted to help him. Jerry's requests for "walking and talking" sessions proved to be the most effective approach. Jill needed support and guidance in her grief, not drugs to numb her pain or analytic scolding. Other situations that would require leaving the office and making a home visit are working with those who are homebound, such as the elderly or those who are sick and bedridden.

The intent of the above examples is not to advocate for therapists leaving the office indiscriminately or habitually. The intent is to present instances where leaving the office was part of a clearly articulated treatment plan which constituted the most effective intervention for the specific situation. Such interventions are consistent with behavioral, humanistic, and cognitive-behavioral orientations (Lazarus, 1974a; Williams, 1997). They neither constitute dual relationships nor violate the APA's, or any other professional association's, ethics code. I could have followed numerous writers' advice to practice defensively by staying in the office no matter what. However, by following that advice I would have been providing substandard care and, in fact, I would have been committing ethical violations of the mandate to ". . . improve the condition of both the individual and society." (APA, 1992, p. 1597) and the mandate of "avoiding harm" (APA, 1992, p. 1601).

When out-of-office experience enhances therapeutic effectiveness

After three months of pre-marital, system-based therapy, a couple invited me to their wedding. I accepted the invitation and was surprised and honored when they publicly acknowledged my role in cementing their nuptial commitment.

An adolescent girl sought therapy to help her with her fear of public speaking, which prevented her from participating in her school play. Her performance on opening night, to which she invited me, was magnificent.

A sculptor came to see me for a severe artist's block. After three years of in-office, intensive, psychodynamically oriented therapy, he invited me to his first one-man show at a local gallery. It was an impressive exhibit.

After a couple of months of dealing with issues of work, creativity, and drug addiction, a landscape architect suggested that we spend a session viewing the actual gardens he had designed. The tour increased my understanding of him and my capacity to help him.

Several couples and individuals, over the years, have invited me to their house-warming parties, weddings, anniversaries, and funerals of loved ones. When appropriate, I have accepted these invitations.

It is important to note that I do not always accede to clients' requests to leave the office. In fact, there are just as many reasons not to leave the office including intentional manipulation and avoidance by the client. I declined to do so, for instance, in the cases of a Borderline woman, a man in the midst of a paranoid breakdown, a relapsing drug user, and a woman who was overwhelmingly attracted to me.

All of the interventions where I left the office were preceded by thorough consideration, were consistent with behavioral, humanistic, and existential treatment plans (Williams 1997) and were geared to enhancing client welfare. All resulted in an increase of therapeutic alliance, knowledge of the clients and, most importantly, enhanced effectiveness of treatment. Similarly, Robin Williams playing the therapist in the movie, Good Will Hunting, decided to effectively break the ice by taking the highly resistive and distrustful young client, played by Matt Damon, to the riverbank for a walk. None of these interventions constituted dual relationships or ethical violations. The "slippery slope" did not turn out to be slippery at all as neither exploitation nor harm nor sexual relationships resulted. Like the first type of out-of-office experience, none of these interventions comply with analytic or rigid risk management standards. After all, clients do not pay for defensive therapy, but for effective therapy.

Out-of-office experiences as part of healthy dual relationships in the community

Susan and I have children the same age. We have chaperoned field trips and sat on committees together at school. At the outset of therapy, we discussed the complexities and potential difficulties of our multiple relationships. She made it clear that she chose me because she knew and trusted me and appreciated my parenting methods and the importance I attach to marriage, family and community. She thought that my knowledge of her would speed up therapy. The daily "Good morning" greetings at school neither interfered with therapy, which progressed well, nor with psychodynamic and transference work.

Sue is a retail clerk at one of the local stores that my wife and I frequent. Unbeknownst to me, she chose to tell my wife, as she checked us out of the store, how I "saved her marriage and helped her children." (My wife is used to it.)

David and Esther were a Jewish couple who had just moved to town. They sought my services due to marital and spiritual concerns. I invited them to my annual Chanukah party where they established several long-lasting connections and reported that the party was an important milestone on their spiritual and communal path.

The American Psychological Association's Ethics Code states clearly that: "In many communities and situations, it may not be feasible for psychologists to avoid social or other non-professional contacts with persons such as patients, clients,..." (APA, 1992, 1601). Several authors have acknowledged that therapists who practice in rural, military, and small communities, or in subcultures of gays, the deaf, or other minorities, often have ongoing, unavoidable, yet not unethical, social and other exchanges with their clients outside the office (Barnett, 1996; Keith-Spiegel & Koocher, 1985).

Unlike the first two types of out-of-office experiences, these community connections with clients constitute dual relationships. They are part of communal life where people are connected and interdependent in a healthy way and are neither isolated nor insulated from each other. Not only were these relationships non-sexual, non-exploitive, and non-harming, they enhanced therapeutic alliance, trust, and effectiveness. Still, therapists should be thoughtful when taking on clients within their community. Some situations and people are not suited to this kind of work. Such were the cases of a hostile man whose son did not get along with my child, a jealous colleague, and a close friend of an ex-lover. A couple of times I had to terminate treatment because the complexity of dual relationships unexpectedly interfered with the clinical work. These terminations provided valuable learning experiences to clients about the importance of re-evaluating plans and rethinking boundaries.

While the analytic approach will eschew socializing with clients, the humanistic, cognitive, or behavioral approaches may not (Williams, 1997). Marquis (cited in Williams, 1997) describes having good clients as friends and good friends as clients. Lazarus (1994a) states, "I have partied and socialized with some clients, played tennis with others, taken long walks with some . . ." (p.257). Jourard writes, "I do not hesitate to play a game of handball with a seeker or visit him in his home-if this unfolds in the dialogue." (Cited in Williams, 1997, p. 242).

Re-Thinking "Slippery Slope" and Boundaries in Therapy

Contrary to popular dogmatic expectation, I did not slide uncontrollably down the "slippery slope" and did not end up sleeping with John, Jean, Max, Susan, Sue, Jerry, or Jill. In fact, the out-of-office

experiences reduced the probability of exploitation because they were carried out in public. The tyrannical creed propounding the 'only in the office' policy and the isolation it imposes on the therapeutic encounter, is one of the main contributors to exploitation and sexual misconduct (Zur, 2000a).

Leaving the office is not the norm in my practice. It occurs only when there is clinical evidence that it would enhance effectiveness of treatment or it is unavoidable in the community. Like most professions, therapy involves contacts and reputation. Almost all of my clients chose therapy with me because they either know me personally or heard about me from a trusted friend. It may surprise the reader that one of the several therapeutic modalities I use with my clients is psychodynamic therapy and that none of the out-of-office experiences described in this article have interfered with transference and psychodynamic work when they were applied. Meeting outside the office, like knowing me personally, makes the transference more reality-based and just provides more "grist" for the (transference) mill.

Lazarus (1994a) has stated succinctly that, "One of the worst professional or ethical violations is that of permitting current risk-management principles to take precedence over human interventions" (p. 260). Indeed, in some situations, not leaving the office, due to defensive practice consideration, can constitute substandard care and an ethical violation.

One of the goals of this article is to free therapists to intervene according to clients' specific situations and presenting problems and not according to fear of attorneys, licensing boards or analytic dogma. There are situations where interacting with clients outside the office is the best intervention and there are situations where it is clearly counter-indicative. As Lazarus (1994b) summarizes it simply: "It depends."

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Rethinking The Prohibition On Touch In Psychotherapy And Counseling

Clinical, Ethical & Legal Considerations

Ofer Zur

Introduction

Touch is one of the most essential elements of human development, a profound method of communication, a critical component of the health and growth of infants, and a powerful healing force (Bowlby, 1952; Harlow, 1971, 1986). Ample research has demonstrated that tactile stimulation is extremely important for development and maintenance of physiological and psychological regulation in infants, children and adults (Field, 1998; Montagu, 1971, 1952). Touch has been an essential part of ancient healing practices. Touch has roots in shamanic and religious practices, and is reported to have been an integral part of health care practices and medicine since their emergence from the realms of religion and magic (Levitan & Johnson, 1986; Smith, Clance & Imes, 1998).

Primarily Euro-American cultures in general, particularly that of North American white-Anglos, have developed a set of unspoken taboos in regard to touch. Based on Cohen (1987) and Hunter and Struve's, (1998) work, following are short descriptions of these cultural, mostly unspoken, taboos:

"Don't touch the opposite gender!" This taboo is based on the belief or worldview that sexualizes all or most forms of touch.

"Don't touch same gender friends!" This boundary is primarily based in the homophobic fears prevalent in our culture.

"Don't touch yourself!" This injunction stems, in part, from some religious and puritanical doctrines and phobias around self-pleasure and masturbation.

"Don't touch strangers!" This command is based on a cultural fear of "the other," a paranoid attitude towards unfamiliar persons and those who are outsiders of one's own group.

"Do not touch the elderly, the sick and the dying!" This reflects a negative attitude in American culture towards the elderly, the sick, and the dying that manifests itself by segregating them from the rest of the population. The sick and the elderly are often housed away in specialized board and care facilities, where much of time hospital staff do not value touch as an essential part of care.

"Do not touch those who are of higher status!" This unspoken rule is prevalent in our culture, where it has been documented that people of higher status or power touch those of lesser status significantly more frequently than the converse.

General Points and Ethical and Clinical Guidelins about Touch in Psychotherapy

THE GENERAL SIGNIFICANCE OF TOUCH

Touch is one of the most essential elements of human development: a form of communication, critical for healthy development and one of the most significant healing forces.

In his seminal work, Touching: The Human Significance of the Skin, Ashley Montagu (1971) brought together a great array of studies demonstrating the significant role of physical touch in human development.

The effects of touch deficiencies can have lifelong serious negative ramifications.

Bowlby and Harlow, among many others, concluded that touch, rather than feeding, bonds infant to caregiver.

Touch has a high degree of cultural relativity. People of Anglo-Saxon origin place low on a continuum of touch while those of Latin, Mediterranean and third world ancestry place on the high end.

The general western culture and its emphasis on autonomy, independence, separateness and privacy have resulted in restricting interpersonal physical touch to a minimum. America is a low touch culture.

In Western society, sex, love, power and dominance are dangerously confused.

Americans tend to sexualize or infantilize the meaning of touch and as a result tend to avoid touch. Watson, parenting expert of the early 1900's, cautioned mothers not to sexualize their infants by kissing or hugging them affectionately.

TOUCH AND HEALING

The medicinal aspect of touch has been known and utilized since earliest recorded medical history, 25 centuries ago.

Touch unleashes a stream of healing chemical responses including a decrease in stress hormones and an increase in seratonin and dopamine levels.

Touch increases the immune system's cytotoxic capacity thereby helping our body maintain its defenses.

Massage has been shown to decrease anxiety, depression, hyperactivity, inattention, stress hormones and cortisol levels.

Massaged babies are more sociable and more easily soothed than babies who have not been massaged.

TYPES OF TOUCH IN PSYCHOTHERAPY

Therapeutic touch as an adjunct to verbal therapy
Therapists can deliberately employ many forms of a touch as part of verbal psychotherapy. These forms of touch are intentionally and strategically used to enhance a sense of connection with the client and/or to sooth, greet, relax, quiet down or reassure the client. These forms of touch can also reduce anxiety, slow down heartbeat, physically and emotionally calm the client, and assist the client in moving out of a dissociative state. Following are examples of different types of touch in therapy:

Ritualistic or socially accepted gesture for greeting and departure: This form of touch is used as a greeting or departure ritual. This might include a handshake, greeting or departing embrace, a peck on the cheek, tap on the back, and other socially and culturally accepted gestures. These gestures vary from culture to culture and from sub-culture to sub-culture.

Conversational Marker: This form of touch, which takes place during a conversation, is intended to make or highlight a point, or to get the client's attention. It often manifests as a light touch on the arm, hand, back or shoulder. When a therapist and client are in sitting positions, as they mostly are in psychotherapy, the touch may be on a knee. Accentuated touch or physical punctuation can also take place at times of silence or stillness, often with the purpose of accentuating the therapist's presence and conveying attention.

Consolation touch: Holding of the hands or shoulders of a client, or providing a comforting hug usually constitutes this kind of supportive or soothing touch. It is most often done in response to grief, sorrow, distress, anguish, agony, sadness or upset. This is one of the most important forms of touch and is likely to enhance therapeutic alliance.

Reassuring touch: This form of touch is geared to encourage and reassure clients and usually involves a pat on the back or shoulders.

Playful touch: This form of touch may involve play wrestling with a child in therapy or in family therapy involving children. It might also take place in non-traditional types of therapy, such as when a therapist plays basketball with an adolescent who has not been responding to traditional verbal only-in-the-office therapy.

Grounding or reorienting touch: This form of touch is intended to help clients reduce anxiety or dissociation. It usually involves helping a client be aware of his or her physical body by employing touch to the hand or arm. It can also be done by helping a client touch the fabric of the chair or sofa they are sitting on or by leading them to touch their own hands or head.

Task-Oriented touch: This involves touch that is merely auxiliary to the task at hand, such as offering a hand to help someone stand up or bracing an arm around a client's shoulders to keep them from falling.

Corrective experience: This form of touch may involve the holding or rocking of a client by a therapist who practices forms of therapy that emphasize the importance of corrective experiences. This can take place with both adults and children.

Instructional or modeling touch: This form of touch is usually part of a therapist's instructions or modeling regarding how to touch or respond to touch. It can take place in individual, group or family therapy. Therapists may model or demonstrate how to give a firm handshake to a shy client or how to hold a child who throws a tantrum. It may also be used to teach clients how to respond to unwanted touch.

Celebratory or congratulatory touch: This form of complimentary or approval touch can be manifested in a "high-five," a pat on the back or a congratulatory hug with a shy client who finally spoke out in group therapy, a historically passive client who asserts himself or herself in couple or family therapy or a child who has succeeded with a goal or good effort toward a goal.

Experiential Touch: This form of touch usually takes place when the therapist conducts an experiential exercise, such as in family sculpturing or in teaching gestures during assertive training.

Referential touch: This is often done in group or family therapy. The therapist can lightly tap the arm or shoulder of a client, indicating it is time for that client to speak or take his or her turn. This form of touch can also be used to reference or bring certain body parts into attention, or to indicate to the client that it is good for him or her to take a moment of silence.

Inadvertent touch: This is an accidental form of touch, such as an inadvertent brush against a client by the therapist. It refers to touch that is unintentional, involuntary, chance or unpremeditated.

Touch intended to prevent a client from hurting his/her self: This type of touch is intended to stop self-harming behaviors, such as head banging, self-hitting, self-cutting, suicide attempts or suicidal gestures. It also includes the appropriate restraint of an out-of-control young child.

Touch intended to prevent someone from hurting another: This form of touch is intended to stop or restrain someone from hurting another person, as sometimes happens in family, couple or group therapy or when working with extremely volatile, antisocial or chronically mentally ill clients. This includes situations in which the therapists must physically intervene by restraining, holding or escorting the client away so he or she will not hurt someone else. Staff of mental institutions and inpatient hospitals typically utilizes this kind of touch more frequently than most practitioners in private practice.

Self-defense: This form of touch is used by a therapist to physically defend him or herself from the assault of a violent client. Many therapists, especially in institutions, are specially trained in self-defense

techniques that restrain clients with minimum force and minimum physical injury to clients.

Inappropriate forms of touch:
The following last three forms of touch, sexual, hostile and punishing are all unethical and depending on the state, are also illegal in psychotherapy. They are counter-clinical and should be avoided.

Sexual Touch: The initiator of this form of touch intends to sexually arouse the therapist, the client or both. It often manifests itself in a therapist touching the client's sexual organs, buttock, breasts, stomach or mouth. However, sexual touch has been reported to manifest in many other forms such as nibbling on client's ears or stimulating a man's nipples. This form of touch between therapists and current clients is always unethical, counter-clinical and also illegal in many states.

Hostile-Violent touch: This form of touch involves a therapist being physically hostile or violent with a client. Physical assault is always highly inappropriate, unethical and, depending on the state, may be illegal.

Punishing touch: This is another inappropriate form of touch where a therapist punitively punishes a client for "undesired behavior." This form includes slapping a child-client on the buttock or slapping a client on the hand. While preventing a client from hurting him or herself or others may require some physical intervention, physical punishment by a therapist is never appropriate in the context of psychotherapy.

SOURCES OF THE PROHIBITION OF TOUCH IN THERAPY

The general western culture and its emphasis on autonomy, independence, separateness and privacy.

The cultural tendency in the USA to sexualize most forms of touch.

The traditional dualistic Western mind-body or mental-physical split.

Homophobia.

Some fundamentalist religious denominations that have a highly restrictive view of all forms of touch.

The litigious culture and the resulting risk management and defensive medicine practices.

Psychoanalysis and its emphasis on neutrality, distance and rigid boundaries.

Those feminist scholars who assert that any touch by male therapists of female patients is disempowering and injuring to the women.

The fear-based, illogical slippery slope idea that non-sexual touch inevitably leads to sexual exploitation.

The more recent crisis in the clergy and the not too distant daycare hysteria in regard to sexual exploitation.

The slippery slope argument is grounded primarily in the assumption that touch or any boundary crossing, however trivial it may be, inevitably leads to sex and other boundary violations. This argument is based on the finding that most therapists who were engaged in boundary violation had been engaged in boundary crossings prior to their engagement in boundary violations. However, to assert that a hug, self-disclosure, a home visit, or accepting a gift are actions likely to lead to sex is similar to saying that doctors' visits cause death because most people see a doctor before they die (Zur, 2000). Lazarus calls this thinking "an extreme form of syllogistic reasoning" (1994, p. 257). We learn in school that sequential statistical relationships (correlations) cannot simply be translated into causal connections.

The slippery slope notion that primarily touch, but in fact most boundary crossing, will inevitably end up with sex has been identified by Dineen (1996) as part of the more inclusive problem of psychotherapists' sexualizing of all boundaries.

ETHICAL CONSIDERATION OF NON-SEXUAL TOUCH IN THERAPY

Touch in therapy is not inherently unethical.

None of the professional organizations code of ethics (i.e., APA, ApA, ACA, NASW, CAMFT) view touch as unethical.

Touch should be employed in therapy when it is likely to have positive therapeutic effect.

Practicing risk management by rigidly avoiding touch is unethical. Therapists are not paid to protect themselves, they are hired to help, heal, support, etc.

Avoiding touch in therapy on account of fear of boards or attorneys is unethical.

Rigidly withholding touch from children and other clients who can benefit from it, such as those who are anxious, dissociative, grieving or terminally ill can be harming and therefore unethical.

Sexual, erotic or violent touch in therapy is always unethical.

Stopping therapy in order to engage in sexual touch or sexual relationships is unethical and often illegal.

Ethical touch is the touch that is employed with consideration to the context of the therapeutic relationship and with sensitivity to clients' variables, such as gender, culture, history, diagnosis, etc.

Seeking ethical consultation is important in complex and sensitive cases.

Ethical therapists should thoroughly process their feelings, attitudes and thoughts regarding touch in general and the often, unavoidable attraction to particular clients.

Critical thinking and thorough ethical-decision making are most important processes preceding the ethical use of touch in therapy.

Documentation of type, frequency and rationale of extensive touch is an important aspect of ethical practice.

Clinical Considerations for touch in psychotherapy

CLIENTS' PERCEPTION OF TOUCH
Clients, sometimes independent of therapists' intentions, construct the meaning of touch. For example, a light touch on the arm by a therapist meaning to be supportive and affirming may be experienced by a client either, as intended,

supportive, warm, encouraging and affirming, or it may be perceived as hostile, intrusive, controlling and disrespectful. Similarly, a handshake at the end of the session can be perceived as a gesture of respect and affirmation or as indication of the therapist's coldness, rigidity, distance or dislike of the client. A therapist's hug, meant to be supportive, may be experienced as affirming and calming, or as overwhelming, intrusive or as sexual harassment.

Geib (1982) conducted one of the first phenomenological studies of the meaning attributed by clients with regard to non-sexual touch and isolated four factors that are associated with a client's positive evaluation of touch in therapy: Congruence of touch; clarity regarding boundaries in therapy; client's perception of being in control of the physical contact, and client's perception that the touch was for his/her benefit rather than the therapist's. A study done by Horton et. al. (1995) supported Geib's finding that the degree of therapeutic alliance significantly influences the client's evaluation of touch.

Touch, like any other therapists' behavior and interventions should be employed if they are likely to help clients.

Touch increases therapeutic alliance, the factor found to be the best predictor of therapeutic outcome.

Touch can help therapists to provide real or symbolic contact and nurturance, to facilitate access to, exploration of, and resolution of emotional experiences, to provide containment, and to restore significant and healthy dimensions in relationships.

Clinically appropriate touch must be employed with sensitivity to clients' variables, such as history, gender, culture, diagnosis, etc.

Sensitive, attuned touch gets etched into our developing neural pathways enabling us to feel of value, and to connect emotionally with others. As such, touch can be a powerful method of healing.

Language never completely supersedes the more primitive form of communication, physical touch. As such it can have a significant therapeutic value.

The unduly restrictive analytic, risk management or defensive medicine emphasis on rigid and inflexible boundaries and the mandate to avoid touch interferes with human relatedness and sound clinical judgment.

Due to the absence of attention to touch in most training programs, clinical supervision, research and testing, the majority of therapists tend not to incorporate the use of touch in therapy.

Fear, misguided beliefs and lack of training often lead to therapists employing an approach of "touch but don't talk."

Touch that is inappropriate, sexual, cold or abusive can be harmful.

Traumatic memories are encoded in our sensorimotor system as kinesthetic sensations and images, while the linguistic encoding of memory is suppressed. Therefore, appropriate touch can have a significant therapeutic value.

Disturbances in non-verbal communication are more severe and often longer lasting than disturbances in verbal language. Using touch in therapy may be the only way to heal some of these disturbances.

To disregard all physical contact between therapist and client may deter or limit psychological growth.

GUIDELINES FOR CLINICL AND ETHICAL TOUCH IN THERAPY.

Touch should be employed in therapy if it is likely to be helpful and clinically effective.

Avoiding touch due to fear of boards and attorneys is unethical and a betrayal of our clinical commitment to aid clients.

Touch in therapy must always be employed with full consideration to the context of therapy and clients' factors, such as presenting problems and symptoms, personal touch and sexual history, ability to differentiate types of touch, the clients level of ability to assertively identify and protect his or her boundaries as well as the gender, and cultural influences of both the client and the therapist.

Touch should be used according to the therapists training and competence.

Extensive touch should be incorporated into the written treatment planning.

The decision to touch should include a thorough deliberation of the clients' potential perception and interpretation of touch.

Therapists must be particularly careful to structure a foundation of client safety and empowerment before using touch.

Factors that are associated with congruence are; clarity regarding boundaries, patients' perception of being in control of the physical contact, the patient's perception that the touch is for his/her benefit rather than the therapists.

The therapist should state clearly that there will be no sexual contact and to be clear about the process and type of touch that will be used.

Permission to touch should be obtained from clients if the form involves more than a handshake. Extensive use of touch, as utilized in some forms of bodypsychotherapy, is likely to require a written consent.

Touch is usually contraindicated for clients who are highly paranoid, actively hostile or aggressive, highly sexualized or who implicitly or explicitly demand touch.

Special care should be taken in the use of touch with people who have experienced assault, neglect, attachment difficulties, rape, molestation, sexual addictions, eating disorders, and intimacy issues.

Therapists should not avoid touch out of fear of boards, attorneys or dread of litigation. Therapists are paid to provide the best care for their clients not to practice risk management.

Consultation is recommended in complex cases.

Therapists have a responsibility to explore their personal issues regarding touch and to seek education and consultation regarding the appropriate use of touch in psychotherapy.

Bartering in Psychotherapy & Counseling:

Complexities, Case Studies and Guidelines

Ofer Zur

Introduction

Bartering has been an economic arrangement through most of human evolution. It is a dignified and honorable form of payment for those who are cash poor but rich, capable or talented in other ways. It is a healthy part of a norm for many cultures, such as Hispanic, Native American and many agricultural communities. The ethics codes of most professional organizations do not consider bartering as unethical, per se. Unlike the risk management and analytic mandate to avoid bartering, it can also be part of a clearly articulated treatment plan where the benefits of bartering are likely to help the client's mental health and enhance the therapeutic outcome. While bartering of goods is often easier to navigate, bartering of services can be equally beneficial. Bartering, as often stated, does not necessarily lead to exploitation, harm or sex. The slippery slope concept that describes how one deviation from rigid guidelines inevitably leads to harm and sex is a fear based, irrational and unproven concept. Probably for self-serving reasons (Zur, 2004b, 2005) psychotherapists have developed a dogma about the depravity of bartering and place it next to dual relationships on the risk management avoidance list. As the guidelines below outline, it is important to have good discussions, excellent documentation, thorough consultations and clear understanding when therapists and clients make a bartering arrangement.

Summary and Guidelines for Bartering in Psychotherapy

General Points:

Barter is the acceptance of services, goods or other non-monetary remuneration from clients in return for psychological services.

Bartering is not inherently unethical, illegal or counter-clinical.

Bartering is common with poor clients who seek or need therapy but do not have the money to pay for it.

Bartering for psychotherapy is also very common in cultures and communities where bartering is an accepted norm for compensation and exchange.

Bartering that is likely to benefit clients can be part of a clinical intervention, negotiated with clients and articulated in the treatment plan.

Bartering can be of goods (chicken, painting, furniture, etc) or of services (automobile repair, plumbing, graphic design, etc.).

Some poor agriculture communities may have more flexible bartering schedules where the arrangement is a chicken and some fresh produce for each session.

Most analytically oriented therapists, consumer protection agencies and risk management experts frown upon bartering. The traditional analysts view bartering as interfering in transference analysis. Licensing boards, ethics committees and risk management experts often view bartering as potentially exploitative and damaging to the therapeutic work.

Most of those who oppose bartering reluctantly acknowledge that bartering can be an acceptable practice with poor people and is a normal and healthy aspect of certain cultures and communities.

Bartering has often been equated, mistakenly, with dual relationships and boundary violation. While bartering of services is, indeed, dual relationships, bartering of goods is generally not. As with many types of dual relationships, bartering of services can be clinically beneficial and ethically sound. All bartering is boundary crossing but not necessary (harmful) boundary violation.

Bartering does not necessarily lead to exploitation, harm or sex. The slippery slope concept that describes how one deviation from rigid guidelines inevitably leads to harm and sex is a fear based, irrational and unproven concept.

Almost all ethical guidelines do not mandate a blanket avoidance of bartering. All ethical guidelines prohibit exploitation of clients.

Bartering arrangements also have tax implications. Consult your tax preparer and make informed decisions regarding your legal, civic and professional responsibilities.

Avoiding all bartering agreements will abandon thousands, or even millions, of people who are in need of therapy but do not have the cash to pay for it.

Most graduate and post graduate education not only instill a fear of licensing agencies and lawsuits, but also deliver inadequate instruction in personal integrity, individual ethics and how to navigate the complex issues of bartering and other boundary issues in therapy.

Clinical and Ethical Considerations:

In planning on entering into a bartering agreement, therapists must take into consideration the welfare of the client, his/her culture, gender, history, condition, wishes, economic status, type of treatment, avoidance of harm and exploitation, conflict of interest and the impairment of clinical judgment. These are the paramount and appropriate concerns.

Make sure that the client involved in the negotiation fully understands and consents, in writing, to the agreement.

Include the bartering arrangement in the document that explains the payment agreement, and have the client sign the appropriate informed consent.

Make sure that your office policies, when appropriate, include the risks and benefits of bartering and that they are fully explained to, read and signed by your clients before you implement them.

The bartering arrangement must be well documented in the clinical notes.

Make sure that the bartering agreement is consistent with and is not in conflict with the treatment plan.

It is important to realize that bartering can be counter-clinical in some situations such as with borderline clients or those who see themselves primarily as victims.

Do not let fear of lawsuits, licensing boards or attorneys determine your fee agreements, treatment plans or clinical interventions. Do not let dogmatic thinking affect your critical thinking. Act with competence and integrity while minimizing risk by following these guidelines.

Remember that you are being paid to provide help and care not to practice risk management.

Differentiate when and what types of bartering are best suitable to each client and situation.

Consult with clinical, ethical or legal experts in complex cases and document the consultations in your clinical notes.

Attend to and be aware of your own needs through supervision and consultations.

At the heart of all ethical and clinical guidelines is the mandate that you act on your client's behalf and avoid harm. That means you must do what is helpful, including bartering when appropriate.

Keep excellent written records throughout treatment if or when problems and complications arise with regard to the bartering agreement.

Evaluate the effectiveness and appropriateness of the bartering arrangement regularly and change it if necessary through discussion with and, hopefully, consent from your client.

If complications, negative feelings or disagreement arise due to the bartering agreement, discuss it with your client, get consultations and change it in a way that will be most helpful to the client and conducive to therapy.