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RESPONSE PAPER

Boundary Management for Cognitive Behavioral Therapies

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In recent years, the scholarship regarding professional boundaries has increased significantly in a variety of areas. Despite many advances in this line of research, less attention has been devoted to the question of boundary maintenance and its relationship to theoretical orientation. In this article we examine these issues for cognitive-behavioral therapies. After a brief historical review of the evolution of the concept of boundaries, we select three procedures integral to cognitive-behavioral practice and discuss how they may create boundary problems for practitioners. We conclude with recommendations for practice.

Psychotherapy usually involves the development of close personal relationships that generally exist in private. In combination with the power differential between practitioner and patient, this context can create situations in which boundaries can be violated and patients harmed. Because of the nature of the work, it is not surprising that maintenance of appropriate professional boundaries between practitioners and patients has received much attention. Although some serious boundary violations, such as sexual relations with patients, have been resolved, a host of others remain, and they can cause vexing dilemmas. To make matters more complex, cognitive behavior therapy (CBT) often employs more innovative and directive methods. As a result, some distinct and even unique questions regarding appropriate boundary maintenance may be more likely to arise.

In this article, we selectively review the scholarship regarding boundaries, including some contemporary work devoted to different practice niches. Then, we select three procedures basic to CBT practice that may involve nontraditional approaches to treatment and discuss how boundaries may be more effectively managed in those situations. We conclude with recommendations for practice.

A Brief History

Sexual Relations

The early history of psychotherapy is filled with notorious examples of sexual liaisons between patients and their therapists. In part, this may have been due to the assumption that a successful psychoanalysis led to equality in the relationship. That is, at some point power differentials disappeared, and it then became acceptable to engage former patients as peers. We believe that this behavior persisted until two forces brought about change.

First, patients were treated in a highly paternalistic manner. Doctors knew best, and it was not necessary to inquire regarding the preferences of patients. A legal foundation for informed consent was laid as early as 1914 in *Schloendorf v. Society of New York Hospital*, but it was only after the Nazi experiments of World War II were revealed that change accelerated. Today patients are considered autonomous actors who are entitled to information sufficient to make decisions regarding their own care based on their values and personal preferences. (For a more detailed discussion, see Beauchamp & Childress, 2001.)

Second, power differentials in society were largely ignored until the women's movement began to focus on issues such as male entitlement and women's exploitation. This work first led to a strong emphasis on the empowerment of women; it soon was applied to psychotherapy patients of both sexes (e.g., Feminist Therapy Institute, 1987).

All this may seem like ancient history until we realize that the American Psychological Association (APA) did not prohibit sexual relations with patients until 1977 (APA, 1997), but the prohibition did not end the debate. In the years immediately following that decision, another controversy arose. If it was not acceptable to have sexual relations with patients, what was wrong with becoming involved with former patients? Two surveys provided the answer. Dating from the early 1980s, Sell, Gottlieb, and Schoenfeld (1986) and Gottlieb, Sell, and Schoenfeld

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Continuing Education Quiz located on p. 242.

(1988) showed that state regulatory boards were uniformly holding practitioners accountable for sexual involvement with former patients. They provided no rationale for their findings. We can only surmise that the state boards viewed such behavior as boundary violations that were every bit as serious as sexual involvement with current patients. These data, along with other forces, led the APA to modify its ethics code once again by making it all but impossible to engage in sexual relations with former patients (APA, 1992). These steps put an end to the question regarding sexual relations that had endured since the beginning of psychoanalysis, but it was not the end of the debate regarding multiple relations and other boundary issues.

Boundaries: An Evolving Concept. With the issue of sexual relations resolved, the profession began to focus on what kinds of relationships practitioners could have with patients and still remain within ethical boundaries. It soon became obvious that this was a very complex problem, especially for those who worked in a variety of contexts, such as rural areas; confined religious communities; the military; university settings; and the lesbian/gay/ bisexual/transgender communities. During this period, four developments occurred that provided a major advance in the thinking of the profession.

First, terminology changed. Originally, the term *dual relationships* was used, mostly to describe inappropriate sexual contact with patients. In the early 1990s, this term was abandoned in favor of *multiple relationships* (APA, 1992). This was a helpful modification because it more accurately reflected the complexity of contemporary practice and emphasized that professionals could have a variety of relationships with the same patient. Second, the profession came to understand that complexity was not tantamount to unethical behavior and that practitioners could have multiple relations that were not necessarily harmful or exploitive (e.g., Gottlieb, 1993; Younggren & Gottlieb, 2004). Third, attention focused on harmful multiple relations that were not sexual in nature. This step was important because the profession realized that patients could be exploited in a wide variety of ways. Finally, a critical distinction was made between boundary violations and boundary crossings. Gutheil and Gabbard (1993) defined boundary violations as "harmful crossings" or "transgressions." Later, Smith and Fitzpatrick (1995) suggested that boundary crossings were departures from commonly accepted practice that may or may not benefit the client. This distinction provided a basis for helping practitioners make judgments, in collaboration with their patients, regarding what types of appropriate nontherapy contact might be permissible.

Unfortunately, these developments did not resolve the controversy. Rather, some authors (e.g., Lazarus & Zur, 2002; Williams, 2002; & Zur, 2007) passionately argued that state regulatory boards were effectively proscribing a wide variety of legitimate practices, particularly cognitive/behavioral interventions that could be helpful to patients. First, they contended that the rules unnecessarily restricted a practitioner's ability to treat people in other than traditional ways, thereby precluding benefits that could come from more flexible approaches that more closely matched treatment plans to clinical presentations. Second, they complained that the rules were so narrow and restrictive that they made practitioners more vulnerable to licensing board complaints and civil actions. Finally, they believed that the profession was unable to develop more effective treatments unless some increased degree of flexibility in dealing with boundaries was possible (Zur, 2007). There is little question that these authors and others were successful in increasing the flexibility of the 2002 Ethics Code as compared with the earlier version (APA, 2002).

From this brief review, we conclude that the relationships practitioners have with patients, and the boundaries they maintain, are not and cannot be fixed by rigid rules. We view this as a healthy development: It reflects the increased variety of services offered and the diversity of contemporary practice niches occupied by contemporary professional psychologists. On the other hand, these developments also create the possibility that practitioners will have more complex relationships with patients that may place them in circumstances where they must defend the logic of their boundary maintenance choices to others. This complexity is especially relevant for some cognitive-behavioral therapies where patients are treated in ways that may differ from traditional notions of how therapeutic boundaries should be maintained. Below we select three basic cognitive-behavioral procedures that may raise questions of boundary maintenance for practitioners: modeling/self-disclosure; out-of-office practices; and the therapeutic relationship.

Relevant Procedures

CBT represents a family of interventions that have their roots in earlier behavioral and cognitive models of assessing and treating mental illness (Brewin, 1996). Individual practitioners may utilize both cognitive and behavioral interventions to different degrees in their application of various CBT approaches (McGinn & Sanderson, 2001).

Since the advent of CBT, empirical data have expanded the utility of these interventions from depression and anxiety, to PTSD, eating disorders, relational problems, OCD, chronic pain, hypochondriasis, and personality disorders (Butler, Chapman, Forman, & Beck, 2006). These advances are welcome, but they also may create

new dilemmas regarding boundary management. Below we discuss three CBT procedures that may be more likely to generate boundary maintenance dilemmas.

Modeling/Self-Disclosure

Modeling and/or self-disclosure occur when a therapist provides personally relevant information to clients, with the intent of improving outcome. Bandura (1986) was one of the first to discuss the positive impact of modeling behavior within the context of behavior therapy based upon his earlier work on vicarious learning. Later, Goldfried, Burckell, and Eubanks-Carter (2003) examined the utility of modeling and self-disclosure in CBT. They identified several ways in which self-disclosure could be beneficial to clients, including: providing feedback; enhancing motivation; strengthening the therapeutic alliance; normalizing a client's experience; reducing fears; and modeling more effective ways of coping. Although they identified several positive consequences of self-disclosure and modeling, minimal attention was devoted to its potential risks, and more recent work raised the question of whether it is linked to better outcomes at all (Kelly & Rodriguez, 2007).

Out-of-Office Practices

Practicing outside of one's office is relatively common. For example, practitioners frequently see seniors or disabled individuals in various treatment settings including nursing homes, assisted-living facilities, or patients' homes. Therapists who treat children may visit a patient's school to design a behavior management intervention or hold some treatment sessions outdoors. Military psychologists may see their patients in a variety of unique settings including those where they could be exposed to enemy fire or in field hospitals. Furthermore, practitioners may deviate from traditional outpatient office procedures to treat disorders such as such as specific phobias, obsessive-compulsive disorder, social phobia, posttraumatic stress, panic disorder, and severe depression. For example, in a recent case study, Bram and Bjorgvinsson (2004) documented the practice of visiting a patient's home and discussed the risk management procedures involved in such an endeavor, including careful documentation of the rationale for the procedure, informed consent, explanation of intervention procedures, and accompaniment by another clinician.

Out-of-office procedures typically involve behavioral interventions, such as in-vivo exposure, intended to reinforce some and extinguish other specific behaviors. Although the utility of these practices has been documented in the literature, little information is provided regarding the ethical considerations involved when employing out-of-office interventions.

The Therapeutic Relationship

The importance of the therapeutic relationship is well documented within the CBT literature (Keijsers, Schaap, & Hoogduin, 2000), especially in the context of treating personality disorders (Beck, Freeman, Davis, & Associates, 2004). For example, the structured and goal-oriented nature of CBT requires a strong therapeutic and collaborative alliance between the practitioner and the client. Indeed, two newer treatment approaches, Cognitive Behavioral Analysis System of Psychotherapy and Functional Analytic Psychotherapy, place a strong emphasis on interpersonal dynamics within the therapy session (Kohlenberg & Tsai, 1994; McCullough, 2003). Keijsers et al. (2000) identified two clusters of interpersonal behaviors that were clearly associated with outcomes in CBT. These included client-centered therapist variables (empathy, warmth, positive regard, and genuineness) and the therapeutic alliance. If the relationship is important, then attention to patient-practitioner boundaries must also be, and it has received some attention in the literature (e.g., Beck et al., 2004; Newman, 1997).

The three procedures noted above (modeling/self disclosure, out-of-office interventions, and the therapeutic relationship) are well-grounded scientifically and demonstrably beneficial. At the same time, they may generate ethical dilemmas that risk patient welfare and create vulnerabilities for practitioners. Below, we discuss some of the issues that may arise with each one.

Managing Boundaries in CBT Practice

In this section we address some of the ethical dilemmas that may arise from the basic procedures discussed above. In doing so, we assume that CBT practitioners are generalists who use a broad range of techniques and see a wide variety of patients functioning at differing levels of integration.

How Much Should I Disclose About Myself?

As we noted above, the value of self-disclosure is well established. Unfortunately, there are few guidelines for CBT practice when it comes to deciding how much information to disclose and under what circumstances. Below we address two major issues that may arise in CBT practice.

- *Therapeutic Focus.* Sound practice dictates that clinicians evaluate patients both diagnostically and from the perspective of their overall level of integration in order to determine the case conceptualization or "therapeutic focus." This term refers to "the basic elements that comprise any given treatment modality. They include: a concentration on the past or the present; a focus on affect or cognition; and an emphasis that is more concrete or abstract" (Gottlieb & Cooper, 2002, p. 561).

For example, consider a 27-year-old female who presents with what appears to be an acute, single depressive episode with anxious features precipitated by the rejection of a lover. There are well-established CBT procedures for such patients, and they would be considered a treatment of choice for this clinical presentation (Dobson, 1989). If the diagnosis were correct, the patient should respond promptly, and the treatment will be brief. In such cases, would self-disclosure be appropriate? We think the likely answer would be yes. For example, we find little wrong with a practitioner who might refer to his/her own prior depressive episode for the purpose of modeling how it was successfully managed. But, things are not always so simple.

What if, after a few sessions, the practitioner learns more about the patient and begins to observe traits and features that suggest a borderline, narcissistic, or antisocial organization? The new information will most likely lead to revisions of the diagnosis, treatment plan, and therapeutic focus. This example is hardly unusual, and if the practitioner had not previously self-disclosed, boundary management might require little if any modification. However, problems may arise if the practitioner previously disclosed certain personal information to this type of patient.

Self-disclosure fosters a more informal and egalitarian atmosphere, and for more well-integrated patients doing so may be indicated and beneficial. In fact, practitioners are more likely to self-disclose to such patients (Kelly & Rodriguez, 2007). When patients are better integrated, they are more likely to maintain better boundaries themselves and respect those of others (Johnson & Waldo, 1998). Hence, self-disclosure with such patients may involve some boundary crossings (Smith & Fitzpatrick, 1995), but we contend that doing so is less likely to be interpreted as or lead to boundary violations.

However, patients with personality disorders have a poorer sense of their own boundaries as well as those of others (e.g., Bennett et al., 2007, p. 78; Pfohl, 1999). Therefore, if a practitioner self-discloses to such patients, therapeutic effectiveness may be compromised. For example, a more informal and egalitarian atmosphere may inadvertently foster a sense of greater intimacy that does not exist. Acting on such assumptions, patients may behave in ways that practitioners can find manipulative and/or intrusive. Yet, having previously self-disclosed, the practitioner may feel trapped into continuing to reveal personal information in order to avoid being perceived as inconsistent, indecisive, uncaring, aloof, and/or punitive. Unfortunately, the practitioner is now at risk for losing control of the treatment and beginning down the slippery slope toward allegations of boundary violations (Gutheil & Gabbard, 1993). To avoid this, the practitioner must act promptly by informing the patient of the revised diagnosis; deciding if he or she is still the best person to treat the patient; and if so, establishing firmer boundaries and adhering to them in a consistent manner. If the patient does not respond well to these modifications or refuses to comply with the practitioner's attempt to restructure the relationship, termination may become appropriate (Younggren & Gottlieb, 2008).

- *The Practitioner's Motives.* A second issue regarding self-disclose is the practitioner's motivation. Many CBT approaches avoid terms such as *countertransference* because of its reference to psychoanalytic assumptions regarding unconscious motivation, and we do not feel compelled to use it. But, good practice dictates that practitioners of all theoretical orientations be aware that patients can generate strong feelings in them. These feelings may be based in reality, but they may also result from the practitioner's attributions that have more to do with themselves and less to do with the patient (e.g., Rusbult & Van Lange, 2003).

Regardless of one's theoretical orientation, all practitioners are human beings who experience personal struggles of varying magnitude at different times in their lives. When practitioners are distressed, they may self-disclose inappropriately and use the treatment setting for their own benefit. Doing so may be harmful to patients and may be the first step down the slippery slope that alters the therapeutic relationship and leads to boundary violations (Gutheil & Gabbard, 1993; Younggren & Gottlieb, 2008).

Consider the following example: Dr. I. M. Hurt treated children's behavior disorders and frequently used his own childrearing practices as examples to help patients with their own children. But his home life suffered, and after many years of failed attempts to improve the relationship, Ms. Hurt filed for divorce. Her decision caught Hurt by surprise, and he felt devastated. To cope with his distress, and the added financial burden, he threw himself into his work. One of his patients was Ms. U. R. Acutie and her son who was having behavior problems subsequent to his parents' recent divorce. During a session, Dr. Hurt found himself remarking how attractive she was and that he was going through a divorce himself. Ms. Acutie did not respond to these remarks and the session ended without incident. Afterwards, Hurt found himself thinking about what he had said. He knew he found her very attractive and realized that he had been having fantasies about her. The next day he called a classmate from graduate school, Dr. I. Gotyur Back, and asked her to have lunch with him. During the meal he told her what had happened, and it did not take Dr. Back long to realize what had happened, and she gently confronted him about his behavior. This helped confirm his own concerns. At the next session with Ms. Acutie, he monitored his feelings and behavior closely and avoided similar remarks, but he also realized how

strong his feelings were for her. Now he saw that the strength of his feelings was indicative of just how distressed he was, and that acting on them was potentially dangerous for both him and his patient. He immediately called a senior colleague and asked if she could take him as a new patient.

Using a more flexible approach to self-disclosure, some CBT practices may create greater risk if patients misinterpret such "flexibility" and view it as unprofessional. This did not happen in the above example; we know of no data to support such a contention, and our experience tells us that this is seldom the case. Furthermore, there are no data to suggest that other theoretical approaches are inherently safer.

Self-disclosure can be beneficial in a large number of clinical situations, but it can be harmful in others. Several considerations for appropriate self-disclosure have been identified, including theoretical orientation; treatment setting; patient population; and individual patient characteristics (e.g., Psychopathology Committee of the Group for the Advancement of Psychiatry, 2001). Even in light of these considerations, the absence of more specific guidelines leaves the burden of good risk management to the discretion of individual practitioners (Sommers-Flannagan, Elliott, & Sommers-Flannagan, 1998). The lack of clear guidelines strongly argues for good self-care (e.g., Newman, 1997) but also suggests not only the need to monitor one's own feelings but to liberally use trusted colleagues as consultants.

- *What Happens if I Leave the Office?* Many cognitive-behavioral therapies recommend treating patients outside of traditional settings when it is clinically indicated and appropriate. But are there risks entailed in doing so? Do these practices present unique vulnerabilities? If so, do these procedures require special attention to informed consent regarding matters such as confidentiality and privacy? From a more traditional perspective, out-of-office practices are boundary crossings (Smith & Fitzpatrick, 1995), but do they create an increased risk of boundary violations or patient harm (Zur, 2007)?

Before examining these issues, consider the example of Dr. Able, who had been treating a man for a social phobia. The treatment began well, and soon it was time for him to practice various exercises she had given him on his own, in vivo. At this point, the treatment slowed as the patient found it very difficult to implement some of her recommendations, such has having a meal alone in public. In order to overcome this obstacle, she recommended that instead of a session in her office, they meet for lunch at a nearby mall.

- *Informed Consent.* When patients consult mental health professionals, they make decisions regarding how much personal information to reveal, and as the relationship progresses, they generally feel comfortable providing more. In the context of a consulting room, disclosing private information is expected by both patients and practitioners: both parties understand that doing so is the means by which patients receive help, but the patient maintains control over the amount of private information he or she chooses to reveal. But this is not the case when the practitioner recommends, as part of the treatment process, that the two meet in public.

In making her recommendation, did Dr. Able incur certain additional obligations regarding informed consent? For example, how can confidentiality be maintained if an acquaintance of one of them comes up to say hello? How much consideration should be given to the way in which the patient wishes to handle the situation? Since patients are unlikely to think of such matters themselves, attention to such details not only represents good risk management but shows respect for patient's privacy, and it enhances their role as a collaborator in the treatment process.

- *Maintaining Boundaries.* A second problem with out-of-office interventions is that of boundary maintenance. In the example above, the practitioner's recommendation is clinically indicated and represents an important component of the treatment plan. But what if, unbeknownst to her, the patient misconstrued her recommendation as a social or romantic invitation? While certainly not typical, such a situation could arise no matter how clearly she explained that the procedure was a part of treatment and an exception to her normal procedures.

We find it hard to imagine that anyone would consider that what the practitioner recommended was ethically improper. But despite her good intentions, the recommendation could have iatrogenic effects that she might have to manage. This is not to say that simply because such risk inheres in the procedure, it should be avoided. Rather, it is something that the conscientious practitioners who choose to use such techniques should contemplate in advance as a matter of avoiding harm.

How Do I Manage Relationship Issues?

Cognitive-behavioral therapies are highly effective approaches that have received extensive empirical support for the treatment of a variety of conditions. Their strength includes a consistent approach and a heightened focus on patient symptoms. But, do these strengths also entail vulnerabilities? May the effectiveness of CBT lull practitioners into a false sense of confidence, permitting them to ignore other issues such as the relational components that are an integral part of the therapy (Keijsers et al, 2000)? More importantly, can such oversights lead to boundary violations?

- *Is there a Slippery Slope?* As we noted above, Lazarus and Zur (2002), Williams (2002), and Zur (2007) have argued that some practitioners are excessively rigid with

regard to boundary management and that such a posture may itself be harmful to patients (Zur, 2007). This argument seems based on the assumption that most practitioners operate from a psychodynamic frame that encourages greater patient-therapist distance than other approaches, such as CBT (Cutler, Goldyne, Markowitz, Devlin, & Glick, 2004). Williams (2002) suggested that such distance serves a risk management function behind which practitioners may hide based on their unrealistic fear of complaints and lawsuits if boundaries are even crossed.

Based on these assumptions, they argued that CBT approaches present fewer risks and therefore do not require the same scrupulous attention to boundary maintenance. We disagree and contend that the issue of managing relationships with patients is more complex for cognitive-behavioral therapies than they seem to suggest.

We agree that their argument regarding incidental contact and boundary crossings has merit and that such encounters are unlikely to create risk for patients or practitioners. We also concur that rigidly adhering to boundaries that do not make sense to patients can be harmful. Our concern arises when such statements are made as broad generalizations. For example, Lazarus (1994) noted that he would not cross boundaries with someone who had a borderline personality disorder, and we certainly agree. On the other hand, as we noted above in our example, one cannot always know who does and who does not have this disorder. It is in this regard that generalizations can be dangerous.

Practitioners who choose to use cognitive-behavioral therapies know that in addition to their technical skills, they must also use the relational skills of client-centered therapy and the therapeutic alliance. That is, CBT is not just a set of cognitive and behavioral techniques that one may apply without a relational context. Rather, we assume that it is the therapy and the relationship that produce effective results (Beck et al., 2004; Keijsers et al., 2000). Therefore, we argue that Lazarus and Zur (2002) oversimplify the situation. When contemplating boundary crossings with patients, relational factors must also be considered.

In taking this position, we are certainly not arguing that boundary crossings under any circumstances automatically send the practitioner down the slippery slope. In fact, we contend that in the vast majority of cases, boundary crossings do not lead to boundary violations (Gottlieb & Younggren, under review). Prudent practitioners of all theoretical orientations who develop sound case conceptualizations and remain alert to the possibility of complications should have little concern.

Zur (2007) seemed to imply that due to the bias of regulators, increased patient risk somehow inheres in a practitioner's theoretical orientation and that some approaches are safer than others. We know of no evidence to support this assertion. Rather, we assume that all practitioners should be mindful of these matters based not only on their theoretical orientation but on a variety of other factors, such as patient risk characteristics, practice context, the potential disciplinary consequences, and therapist factors. Very user-friendly models for evaluating risk are now available, and we encourage the reader to consult them (e.g., Bennett et al., 2007, p. 7).

Discussion and Recommendations

The development of cognitive-behavioral therapies has allowed practitioners to offer efficient and effective treatments to a large number of patients; its benefit cannot be overestimated. At the same time, no theoretical orientation or set of techniques is without its limitations. In this article, we have looked at some risks that CBT presents with regard to boundary crossings and boundary violations. We believe that the vast majority of CBT practitioners, just as their colleagues who practice from other perspectives, are mindful of these issues and generally practice in a safe and effective manner. Nevertheless, everyone makes mistakes, misses cues, can be stressed, and have lapses of judgment. In that spirit, we offer the following recommendations.

1. Perform a comprehensive assessment whenever possible. Doing so enables the practitioner to develop specific treatment goals and examines potential obstacles to achieving them. We hasten to add that assessment should be a continuous process that should employed throughout the treatment process.
2. Although cognitive-behavioral approaches are indicated for many presenting problems, some may not be appropriate for managing boundaries in certain cases. For example, again consider the patient with an underlying Axis II disorder. Here relational self-disclosure and out-of-office procedures should be carefully titrated based on a comprehensive assessment, the data one gathers during the course of treatment regarding the patient's responses, and the patient's current status. Close observance of the patient's reactions can help guide the practitioner's decisions regarding whether boundaries can be loosened or should be tightened.
3. No one set of skills or theoretical orientation is sufficient for treating a general clinical population. Those who practice from a single orientation have an obligation to screen patients to ensure that what they have to offer is appropriate for the patient. Providers of CBT are typically most sensitive to this issue because they offer treatments that are empirically supported. Nevertheless, all practi-

tioners should remain open to referring a patient who does not seem to respond well to therapy.

4. The use of CBT is certainly not precluded when treating more compromised patients. Nevertheless, it is incumbent upon all practitioners to remain mindful of their boundaries of competence, especially when managing more complex and/or difficult cases.
5. It is always important to ensure that the informed consent process is adequate and corresponds to the treatment plan. The elements included in these documents may vary based on one's practice specialty, the populations treated, and the policies of a particular service delivery unit. Whenever boundary crossings are anticipated, one should include provisions that address the procedures to be followed, their rationale, a description of the nature of the contact, and relevant issues of privacy. We hasten to add that such provisions need not necessarily be included in documents signed by all patients at the outset of treatment. Having additional documents available to address these particular situations is certainly prudent, but at a minimum, discussion of such matters should be documented in the patient's chart.
6. Documentation is the *sine qua non* of good risk management. One of us (JNY) has stated that thorough documentation is the next best thing to a friendly witness in court. We do not mention this to create anxiety in the reader. Cognitive-behavioral therapies are safe and effective treatment modalities that, in our experience, have prompted few state board complaints or tort actions. But, even if we knew in advance that no such adversity would arise, we would still recommend thorough documentation as it still represents the highest quality of care. It is also good to remember the axiom of evidence in a courtroom: "If it isn't written down, it didn't happen."
7. Always be respectful and courteous. Such a recommendation may seem gratuitous, but Lazarus has argued that rigid boundary maintenance can produce uncivil if not discourteous behavior that can have disruptive or harmful effects. We agree that such behavior can be harmful; there is never an excuse for it. But, we are unaware of any data that such behavior is the particular province of any one theoretical orientation. This is a matter where we must all be mindful as all are equally vulnerable.
8. Few treatments go as planned. Sometimes practitioners become confused, feel frustrated, and/or lose direction. When such situations arise, reevaluation and consultation are in order. Perhaps nowhere is consultation with a trusted colleague more important than in those situations where boundary management questions arise. This is so because psychologists are no different from anyone else. We are all vulnerable to irrational decision making, particularly when our feelings become involved (Gottlieb, 2008). Not only is consultation an excellent risk-management strategy, but it is an excellent way to help alter a treatment plan in order to better assist a patient.

Conclusion

Originally, we contemplated a different title for this article—"No One Is Bulletproof." It was intended to be irreverent and gain the reader's attention, but it also had a more serious purpose. The practice of professional psychology is generally safe for patients, and very few practitioners are ever disciplined. Yet, "sexual/dual relationship" and "unprofessional conduct/negligent practice" (which include nonsexual boundary violations) remain significant causes for professional discipline by state regulatory boards (Kirkland, Kirkland, & Reaves, 2004). Therefore, it is neither safe nor prudent to ignore the possibility that practitioners can harm their patients. Because CBT is generally safe and effective, it is easy to see how vigilance can be extinguished over time, and we can be lulled into a false sense of confidence that what we do is always beneficial and without risk.

Each population, practice niche, and theoretical orientation carries its own particular risk; this is an unavoidable aspect of practice. However, accepting risk does not render practitioners powerless. Rather, each can develop his or her own ethics policy based on one's individual practice. (For further reading see Gottlieb, 1997.) We encourage readers to look closely at their practices and procedures and to enlist the aid of colleagues who do similar work to assist in this endeavor. Doing so will still not make anyone bulletproof, but such policies increase vigilance. They may also improve one's sleep.

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