Supervision and Boundaries

This is Nola Nordmarken, M.F.T. your host for this recording on supervision of boundaries, part of an online course in supervision by the Zur Institute at www.ZurInstitute.com. I am a Marriage and Family Therapist in Southern California with practices in Santa Monica and South Pasadena. I am also a coauthor with Dr. Zur of several CE courses including Touch in Psychotherapy, The Professional Will, and Home Office Practice as well as articles critiquing the DSM.

Today I will be interviewing Dr. Ofer Zur. Dr. Zur is a licensed psychologist, Fellow of American Psychological Association, instructor, lecturer, ethics consultant, an expert witness and has a private practice in psychotherapy in Sonoma, California. He has been in practice for over 20 years, and is director of the Zur Institute, L.L.C. at www.ZurInstitute.com which offers over 120 innovative, and challenging online continuing education courses for psychologists, counselors, social workers nurses, and other mental health practitioners.

Dr. Zur is most known for his effort to humanize the field of psychotherapy, and counseling, and is a fierce advocate of appropriate, and flexible application of therapeutic boundaries, such as, touch, self disclosure, gifts, etc. Through his writing and his teaching, he has assisted, and asserted that rigid application of risk management protocols of no touch, and no self disclosure can actually be harmful to clients as well as being unethical. In this unique audio, or may I say, pioneer recording, Dr. Zur will explore the intersection of supervision and therapeutic boundaries. So let's start.

Ms. Nordmarken: I might want to start by crossing a boundary and calling you Ofer, instead of Dr. Zur. Would that be okay with you.

Dr. Zur: Yes, that is good, and if I may call you Nola as well.

Ms. Nordmarken: That is fine. Ofer, I remember being at one of your workshops a number of years ago, and hearing you speak about boundaries in psychotherapy. I came from training and supervision that was fairly rigid in terms of compliance with traditional boundaries from a framework of protecting the client from harm, as well as, from some rather fear based tactics related to avoiding legal sanctions of any kind. I often thought that although sometimes these boundaries did support the highest need of the client, often they did not. I suspected that sometimes adhering to these rigid boundaries might actually be harmful. So I found your way of looking at boundaries to be much more applicable to the clinical needs of individual clients, and found this way of thinking freed me up as a clinician to integrate my boundary considerations based on specific needs of each client, rather than using a one size fits all model. Could you start with just the basics by talking about what constitutes boundaries in psychotherapy and supervision.

Dr. Zur: Thank you for the introduction. This is my mission, to put the client's welfare first. I believe that if we serve them right we also protect ourselves in a good way. So defensive medicine, in the most traditional, and rigid way can be harmful to both. To your question regarding what are boundaries in therapy? Boundaries in therapy are issues that involve self disclosure, touch in supervision, touch of the client by the supervisee, the supervisee by the supervisor, Location of therapy, the time, the space, gift exchange by between either supervisee and client, or supervisee and supervisor, dual relationship, bartering, etc. Then we have in more recent years a whole new set of boundaries, we are still finding our way towards understanding them, such as digital boundaries about online self disclosure, supervisee googling supervisor, visa versa. Communication between therapist and clients, or between supervisor and supervisee via text, cell phone, email, chat, conferencing, Skype, and texting. This is a new area of boundaries to be considered in therapy, as well as supervision.

Ms. Nordmarken: It still surprises me that a field we take such a tight stance on specific boundaries. After all, for example, physical touch has well researched over 50 years, and it has been found to be a highly effective therapeutic intervention. On the issue of self disclosure, humanistic psychologists, and feminist psychologists consider self disclosure to be essential. In your writings and teachings you talk about different types of boundaries, what are they?

Dr. Zur: You are absolutely right the main boundary to a clinically proven intervention is ludicrous. So let's try to see what do we mean by boundaries. Boundaries in general define the therapeutic relationship or what has been called the therapeutic frame. And the role of boundaries is to distinguish psychotherapy from social, familial business and other type of relationship. Some boundaries are drawn around therapeutic relationship and some are including concerns, this would be including concerns of time, place, session, fees, and some boundaries are drawn between therapist and client or supervisor and supervisee rather than around them. This would be instead of disclosure type physical contact giving and receiving gifts meeting outside the office texting emailing, etc. So we have these two types of boundaries between and around therapy. Then we have the difference between boundary crossing and boundary violations. This is extremely an important differentiation. Boundary crossing refers to clinical proven intervention, such as touch, self disclosure, etc It refers to any deviation from strict or analytical only in the office emotionally distant form of therapy or deviation from rigid risk management. Boundary crossings are clinical effective intervention, such as self disclosure, home visits, non sexual touch, gift and bartering. In contrast boundary violation occurs when therapist or supervisors cross the line of decency and violate, exploit, or harm their client. These are a few differentiations.

Ms. Nordmarken: I think that is where over the years a lot of the confusion has taken place. I am curious about how you see dual relationships or multiple relationships relating specifically to supervision.

Dr. Zur: That is very good place to start the boundary discussion in supervision. Dual relationship in the most general term it fits in therapy when supervision refers to any situation where multiple relationships exist between therapist and client, or between supervisee and supervisor. For example, dual relationship could be when supervisee or the clients are also friends, are also students, family member, employee, business associate. So whenever the therapist or the supervisor have a secondary

hat in additional relationship, this is when we talk about multiple relationship. The mythology around multiple relationship is that it is always unethical, and it often leads to sex. This is very crazy thinking.

Ms. Nordmarken: That is quite a leap.

Dr. Zur: That is quite a leap. But the fact is that many dual relationship, between supervisor and supervisee, as well as patient and supervisee, or patient and therapist are unavoidable. In small communities, in medical institutions, in training institutions such as the . . . training institution, or a psychoanalytic institution, or a community within a church in downtown Los Angeles, the LGBT community in San Francisco, it is unavoidable. You live in a community, you bump into other people whom you are either being supervised by or getting therapy from. Some of the dual relationships are mandated as in prison settings, or in military settings. You must have a dual relationship in order to function as a supervisor or as a therapist in these settings. Some of them are avoidable as well. This is a general definition of dual or multiple relationships. Then you ask, how does it fit into supervision? This is a very complicated question because there are many types of multiple relationships and multiple loyalties within the supervisory arena. Supervisors who have a relationship with the supervisee have an obligation and legal commitment to the patient. The supervisor has a relationship to be the gatekeeper for the profession. The supervisor has a relationship to the community at large. We have four relationships that take place at the same time just from the supervisors point of view. The supervisee also has multiple relationships inherent in all supervisor/supervisee relationships. The supervisee has relationship with the client, the supervisee has a relationship with the agency, where he or she gets supervision. And the supervisee, of course, also has a relationship with the supervisor. To make things more complicated, intricate, or more complex, the agency, department of mental health, hospital, clinic where supervision often takes place, have issues directly relationship to the supervisee, the supervisor, the client, as well as to the profession, and sometimes to the accrediting agencies. So we have all these complex multiple relationships that co-exist in each and every supervisor relationship.

Ms. Nordmarken: That is a lot for supervisors to consider with dual relationships. Are there state laws governing this?

Dr. Zur: Each state has laws that govern the relationship, regulations by licensing board, code of ethics also impose regulations. The regulations in general are that most supervisors, universities may have their own standards, as well as the department of mental health. Supervisors cannot conduct supervision with their spouse, former spouse, former lover, or student. It is very important that supervisors and supervisees learn the state laws and the professional association's code of ethics as well as the licensing board restrictions.

Ms. Nordmarken: One general injunction, what would that be?

Dr. Zur: It really is state by state. We know from the code of ethics that for therapist's clients, the general injunction is not to get involved in dual relationships that may impair one's objectivity, judgment, or may reasonably lead to harm and exploitation. Often when it comes to supervision, the

bar is higher, due to regulations by the licensing boards regarding who you can conduct or you cannot conduct supervision with.

Ms. Nordmarken: I am curious, I would like to ask questions about self disclosure but first I want to see if there is anything else you want to say on the topic?

Dr. Zur: I think it is important to remember for many supervisees to get supervision in a training institution, . . . psychoanalytic one, university setting. In all of these places, a multiple relationship would be very complicated and unavoidable. The institution . . . in many ways that means graduate students may be on a committee, and they may find themselves at a Christmas party and their supervisor is there as well. The supervisee, in a university setting may find himself or herself with a student on a track team. In small communities, or distinct communities there are numerous unavoidable dual relationships between supervisees and clients, and supervisors and supervisees. I am shocked to see how little is written regarding such a prevalent concern. It seems almost a denial that these situations exist and people demonize dual relationships rather than understanding them. It is, in some regard, a healthy part of complexities of interconnectedness in interconnected communities. It is important for supervisors to acknowledge their multiplicity of loyalties, and the multiplicity of relationships. The supervisor to know that they have an obligation to the profession, the client, the supervisee, the clinic, or the university. Consciously juggle these multiple loyalties rather than ignore or deny them by seeing getting consultation, or reading text. I have a lot of work on dual relationships that people can use or have been using. Before we move to the self disclosure that you mentioned, . . . a relationship that is unavoidable, complex, and rich, and must be acknowledged and taken into consideration in order to provide effective supervision.

Ms. Nordmarken: And that is closely related to self disclosure. How does self disclosure apply in supervision?

Dr. Zur: First, quickly defining it and to make sure we are talking about the same thing, self disclosure is the revelation of personal rather than professional information by the supervisor to the supervisee , or by the supervisee to the client.

Ms. Nordmarken: Then there would be different types of self disclosure?

Dr. Zur: It could be verbal, or non- verbal. I could tell that my oldest son is ready to go to college, that being verbal. Non- verbal , if you were to come to my office and see a picture of me on my motorcycle, you will obtain information about me. It could be intentional, meaning that if I consciously place a picture, or consciously talk to you about something personal. It could be unintentional when I accidentally say something, or when you bump into me in the community as a supervisee or client, and you get to know personal things about me. Some things are unavoidable, such as my accent, gender, or age. Some self disclosure can be avoidable. Then we have the brave new world regarding the digital, or internet self disclosure, which is new territory for all of us. Sometimes the supervisee, or the client may take action to discover information about the therapist, or supervisor, and this would be a different

category. Two more categories would be intentional and unintentional, as I mentioned before, and is an important differentiation as well.

Ms. Nordmarken: I can see also where you spoke earlier about different settings, and that would be a very important factor with regard to self disclosure as well as dual, or multiple relationships. I think

small towns, military bases, reservations, or prisons, and how some self disclosure would be unavoidable.

Dr. Zur: Absolutely. Add to that when you do organization development, you work in certain settings, psychiatric hospital inpatient settings, in sports psychology you may be traveling with your clients, or with your supervisees department, such as where you live, the Los Angeles Department of Mental Health, supervisors are not unknown entities, more semi-colleagues in some regard even though they have legal and ethical duties. Yes, the setting is extremely important.

Ms. Nordmarken: How does that apply to supervision?

Dr. Zur: For example, in small communities, the supervisee will know a lot about the supervisor just being in the community, going to church together, going to a football game together, having children in the same school, going to the gym together, etc. It is not much different within small disabled communities, minority communities, LGBT communities, spiritual communities, etc. In 12 step, sometimes supervisors and supervisees end up in the same AA meeting, or other self help program. As I mentioned earlier, psychiatric hospital, and training institutions are often mix and match with a lot of knowledge about the supervisor, and about the supervisee by the client which is the nature of the setting. If a supervisor uses a home office, it increases disclosure. You wrote a home office continuing education course on Home Office, where you identify multiple ways clients, and supervisees will find information about the supervisor, or therapist by attending the home office session.

Ms. Nordmarken: There is so much that is verbal and non-verbal, and has to do with setting. I am also thinking about how weaves in with special populations.

Dr. Zur: You are correct that there are special populations that would have clinical data that self disclosure is actually extremely effective. Sometimes an LGBT client will call and want to do an interview with the therapist or supervisor by phone and will ask about sexual orientation. Often not because they care whether you are straight or gay, they want to know if you feel comfortable talking about sexual orientation. Clinically, it is important to have a lot of self disclosure within the veterans communities, self help communities, and rehab communities. Parenting is important. If I work with a supervisee with young children, and understand his or her pressures, etc., it helps a lot. If I am able to say, "I know what it feels like not to sleep for the last five months". Spiritual concerns are very important in supervisors, and supervisees, as well as supervisee's client relationship as often clients will ask, "what is spiritual orientation? Do you believe in God?" Due to oppression, and racism, a small ethnic community might feel more comfortable within the group. There is some research that

addresses abused may benefit more working with other abused women, and the only way they would know this would be self disclosure both by the supervisor as well as the therapist.

Ms. Nordmarken: Ofer, what do you see as being some of the most helpful aspects of self disclosure?

Dr. Zur: It is like asking what are some of the benefits of breathing air, or drinking water? It is such a basic part of human nature, the familiarity that comes with self disclosure, increased trust, increased positive therapeutic relationships, and help people learn via modeling. But, most importantly it

increases the sense of familiarity and the comfort zone, which is so important for supervisees. When the supervisees know about the supervisor's relationships, political affiliations, etc., it can have a very powerful effect on the supervisor/supervisee relationship as increased familiarity and trust, and a positive relationship. I know the psychodynamic or the psychoanalytic may find reasons not to do that, and I respect their perspective, but it is important to remember that familiarity comes via transparency is essential for human connection. On the other hand, cold and emotional distance, non- disclosure, rigid supervisors are less likely to be effective because they did not cultivate familiarity and trust. The same is true for psychotherapy and counseling.

Ms. Nordmarken: So in thinking about self disclosure, how would on assess what makes a certain self disclosure with a certain client ethical or appropriate?

Dr. Zur: You are right, different clients will require a different amount, or different type of transparency. Different supervisees may require, need, or benefit from supervisors transparency. Ethically what is important is, when the supervisor, supervisee, or therapist are self disclosing, they have a clear professional clinical rationale that what they disclose to the supervisee, or client is with their welfare in mind. This is one rule to identify that I don't do it because I need to get things off my chest. I do it because my supervisee or my client can benefit from the disclosure.

Ms. Nordmarken: When I think about all the different factors that are regarded in self disclosure, what you said about digital natives vs. digital immigrants, that is a really big one. Also encouraging vs. discouraging styles. What else would you put in that list?

Dr. Zur: You are very familiar with the digital native, digital immigrant, perhaps I will take a minute to explain it. When it comes to self disclosure we have huge generational differences. The young people born into the digital world, and play computer games at age two, five, or six, what we call digital natives, the digital world is their native land, they have a different sense of self disclosure, transparency, or privacy. You and I as digital immigrants were introduced to computers probably in our 30s at best. We had to immigrate into the digital world. Some of us immigrated enthusiastically, and some of us immigrated reluctantly. But, regardless, you go online to You Tube or Facebook, where the natives hang out, and you will find incredible details, private details, nude pictures, what immigrants would call, compromising clothing, drunkenness, drugs, things that would be unheard by a digital immigrant, the older people, the baby boomer generation and above, to even contemplate putting a bulletin board in

the middle of downtown, or the front page of the New York Times. This is what the natives do when they put things on Facebook or You Tube. We see a huge generational divide. When digital immigrants withhold personal information from digital natives, natives just raise their eyebrows, not understanding what's with them. They have such a different sense of privacy. I am still trying to get used to what my kids would put online, and what is my comfort zone. This is a huge difference between generations. Then there is cultural differences. I come from a culture in the middle east we have much more self disclosure than Norway or Sweden, or other European cultures. The Hispanic community in South America would be much more disclosing than North America in general. There is also cultural differences, as well as, personal differences. Supervisors, supervisees, therapists, and counselors need to know the differences.

Ms. Nordmarken: So going back to what you were saying about the digital age and transparency. How can supervisees gain information about their supervisors? I have heard about a level system for that. Can you say something about that?

Dr. Zur: There are many ways that supervisees find information about supervisors. What supervisors need to understand, that supervisees, especially the young ones, will quickly go to Google and do some kind of search, as a habit, while they are texting, watching something on their television or I pads, or whatever their medium. I give it five levels of exploration. The first level is curiosity, when the supervisee with Google the therapist by entering their first and last name, and perhaps a Ph.D., L.C.S.W, or M.F.T. Then the next level would be due diligence. Through research of yelp.com, licensing boards, www.complain.com, this would be an appropriate due diligence search for information about the supervisor, supervisee, or therapist by the client. The third level is intrusive search by going on Facebook, and deceitfully try to become a friend on Facebook. Some people say yes to every friend request because they want to have more friends. So deceitfully you can become a friend of your supervisor if they are indiscriminately accepting everyone that request to be a friend on Facebook. The last level is the illegal search, or cyber stalking. This costs very little money, between $10 or $60. You can find practically all information about the supervisor by paying someone to cyber stalk them. Within ten minutes you can find financial records, criminal records, marital records, and everything else in between.

Ms. Nordmarken: When you think about big brother watching you, big brother is huge in this regard.

Dr. Zur: Big brother does have access to information. I am not sure if big brother cares about the information. Let's say, if big brother cares he can find information. I don't lose sleep on that.

Ms. Nordmarken: So with everything that has changed in the digital era, what can supervisors and supervisees expect from modern day clients?

Dr. Zur: Supervisors can expect that supervisees, as a modern and informed consumer of supervision, will Google them. Similarly, supervisees and clients can find out. . . modern day consumer will Google them. The supervisors may find an evaluation on Yelp.com by the supervisees. They may find web

postings, especially by a disgruntled one. They may find comments on Facebook. It is an open field by supervisees and clients to critique, and harass, sadly so, their supervisor or therapist when there is no easy way to respond when indeed they are being . . . One thing I would like to say to both the supervisors and supervisees, consider anything you post online to be tattooed on your forehead. That means be careful with any kind of posting. This would be very relevant for supervisees who may be exposed to their client or to supervisors, to know that everything they put online is likely to be read by the supervisee or client.

Ms. Nordmarken: There is something that, and I can't remember the name of it right now, but it is a Google search. Do you remember the name of that?

Dr. Zur: You may be referring to the Google alerts?

Ms. Nordmarken: Yes.

Dr. Zur: That is good you brought it up. Actually, I thought you have used it yourself?

Ms. Nordmarken: Yes I have.

Dr. Zur: So you tell us...

Ms. Nordmarken: I googled myself regularly and I do have Google alerts. I have had clients alert me to things that they have found about me on the internet. For me personally, there have been a few instances of benign mistakes, such as where I practice, and false contact information. But, I have known other people who have had some very serious invalid negative comments posted on them.

Dr. Zur: I know that you have your Google alerts. I am very pleased, and I advocate that all supervisors, and all supervisees that are listening to this recording, get Google alerts. So as a supervisor, you know what your supervisees can find about you. And as a supervisee, you know what your clients can find about you. When you go to www.google.com/alerts, it's free. You sign up. For example, I enter different combinations. I enter Dr. Ofer Zur, Dr. Zur, Ofer Zur, Ph.D. or O. Zur. I put about six different combinations in my Google alerts, and each one of them is in quote, and once a week I get all the web pages that include any of these combinations. It doesn't cost anything. You don't need to get it daily, unless there is some big crisis. I suggest all therapists, supervisors, and tell your supervisees, get Google alerts. It is something that needs to be done in this 21st century, regardless as to whether you have a webpage or not. People could complain, write nice things about you, write things that are not accurate, and whatever they do, it is important for you to know because often your clients know about it whether they tell you or not.

Ms. Nordmarken: What would you suggest someone do if they find negative evaluations from clients or supervisors posted on the web?

Dr. Zur: That is a good question, and I will answer it briefly. Don't impulsive, don't protest, consult with experts, if you can, solve it amicably. There are a few organizations that may help you. Call www.reputation.com, or www.eff.org. Get a consultation, but don't protest too loud. If you protest too loud it may bring more negative attention, and damage control would be even harder. At the end of the day you will need to do a lot of surrender. Consult first.

Ms. Nordmarken: Ofer, I would like to shift now, if you will, to one of my favorite topics, gifts in therapy and in supervision.

Dr. Zur: That is an interesting topic. Generally we have more gift concerns between supervisees and clients, rather than supervisors and supervisees. Gifts can be between supervisees and clients, between clients and supervisees, between supervisor and supervisee, between supervisee and supervisor, and the clinic involved. Sometimes parents of children are involved as well. What we need to know about gifts is, it can be appropriate or inappropriate, it can be expensive or inexpensive. Sometimes between the supervisor and supervisee, at the end of supervision, giving an acknowledgement or celebrator gift to the supervisee can be very nice. DVD for a birthday, flowers for a wedding, something symbolic. I am

going to Jerusalem in a week, and I will bring some rocks to some of my clients who ask me to bring rocks from Jerusalem. When I had a supervisee, if it was appropriate, I would bring a rock from Jerusalem, or water from the Jordan River if the supervisee was spiritually inclined, or had meaning for them. These kind of gifts are very appropriate when done with taste, and with the right intention. It is the supervisor's responsibility to monitor the exchange of gifts between supervisee and client, so it is ethical, appropriate, and clinically appropriate. The supervisor has a duty here to be thoughtful about the gift exchange without being rigid. To understand that around the holy days, the end of therapy, a wedding, graduation, birth, confirmation, etc, events like that are appropriate to do a gift exchange. These are some things that supervisors need to oversee, the gift exchanges between supervisee and client, as well as between supervisee and supervisors.

Ms. Nordmarken: So this has to do with the therapeutic relationships, the modality, the process, the timing, culture, age, and orientation?

Dr. Zur: Yes, excellent list. It is a list of the context of therapy, which is what you cited before is relevant for self disclosure. Who is the client, what is the setting, what is the therapeutic modality, what is the relationship, who is the therapist.

Ms. Nordmarken: What does the code of ethics say about gifts?

Dr. Zur: Another mythology here is that the code of ethics have a stand of no gift giving. This is completely untrue. I did a search about this question, the following code of ethics did not even mention the work gift in their code. The American Psychiatric Association, American Psychological Association, California Association of Marriage and Family Therapists, NASW, NBCC, the list goes on and on, but their codes of ethics do not even mention gifts. What is important from an ethical point of view, is that the

gift has to be offered with the welfare of the supervisee or client in mind. So whether the supervisee or supervisor accept a gift from a client, or supervisor accept or give a give to a supervisee. It should have some clinical intention. Not just to buy love or obsessively give gifts. There is one more myth I would like to mention. Some people say inexpensive gifts are always ethical, that is not true because a pornographic card, or an extremely violent card, or just an image costing one cent can be highly inappropriate. Of course, large gifts are very tricky and generally considered unethical. It depends on the situation, but generally very expensive gifts, such as expensive tickets for a baseball game, or a car, etc., are very tricky and considered unethical. Sometime it would be interesting to see a situation where even that may be ethical under very close scrutiny.

Ms. Nordmarken: Let's move on to the next boundary, touch. It is so unfortunate that so much of what is discussed about touch in psychotherapy, or supervision, has to do with how touch can harm. While this is definitely true, there are just so many ways in which touch can be appropriate, helpful, and even healing in the context of therapy and supervision. I am particularly interested in the work of Dr. Tiffany Field, of the Touch Research Institute. They found how loving touch releases a cascade of healing, balancing, neuro chemicals. There are so many types of touch. What are some of them that are particularly relevant to our topic.

Dr. Zur: This is an area where I should interview you. You know about this area much more than I do. More specifically what you said is just beautiful about the importance of touch, how touch is part of human nature, back to the air we breathe and the water we drink. Without touch we could not grow. Without touch we could not develop well. Children who are not touched become antisocial, and very physically ill. So back to the type of touch. Touch can be appropriate or inappropriate, be ethical or unethical, sexual or non sexual, soothing, arousing, or neutral, comforting, or unsettling. It can be initiated by the therapist, by the supervisor, by the client. It can be part of verbal psychotherapy or part of much more body oriented psychotherapy.

Ms. Nordmarken: Ofer, when I think about it. Touch touches at a very deep level. It is literally the first of our senses to develop, and one of the last senses we are aware of as we die. So being so primary, it has such possibility for reaching a person depths, and so sadly, especially in our western culture, touch is tightly boundaried between people of different ages, races, gender, class, and culture. I can see that the whole topic of touch in therapy and supervision must be very complex. Yet we don't learn much about it in our graduate programs, with the exception that much of the time we are told "don't touch". I would like hear your thoughts on this.

Dr. Zur: It is so true and it is so sad that we don't have a semester or two, three, or four of what has been proven to be one of the most important ways that people interact. We mentioned before there are many types of touches, we need to be able to differentiate. In the article that we wrote together, we have touch, . . . conversational, consolation touch, reassuring, playful, grounding, task oriented, where we tell people where to sit or how to walk, coercive, instructional, how to do things, how not to do things, celebratory, a high five, experiential, referential, also sexual, hostile, or violent. It is

important to know that the three types of inappropriate touch both in supervision and in therapy are sexual touch, hostile, aggressive or violent touch, as well as punishing touch.

Ms. Nordmarken: Then there are some of the unspoken western cultural taboos. Such as don't touch the opposite gender, don't touch same gender friends, don't touch yourself, don't touch strangers, do not touch the elderly and the sick, don't touch those who are dying, don't touch those who are of higher status.

Dr. Zur: It is so true. I did a consultation, which was not supervision, but closely related to somebody, and described to them one client that I have, how we spend most of the hour, and she is an elderly woman in her 90s, nobody touches her. She feels like she is untouchable. This is a client I had many years ago back in Berkeley. We sat sometimes for 45 minutes, and all she wanted was to hold my hand. 90 years old, nobody touched her except medical touch when she is admitted to the emergency room, and the medics touch her in the way that medics do. That was all that she needed for healing and connection, to feel that life is worth living. We don't supervise our supervisees well around these issues of touch, we don't teach them how to touch. And as a result, we take this risk management, idiotic idea that you are being safer from lawsuits if you don't touch, safer from court complaints if you don't touch, which is not based on any statistic or research. It is the opposite, the better relationship you have with your client or the supervisee, the less they are likely file a complaint. Touch would be one way to affirm the connection. Of course, you and I can talk about touch for a long time.

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Ms. Nordmarken: Just quickly, when I think about boundary crossings rather than boundary violations, and ethics in touch, it reminds me of a story I heard you tell about a female client reclining in bed and her male therapist is there with her. Could you tell that story quickly?

Dr. Zur: This is a story about context. It came partly from Gerald Kutcher. It is a variation of his story. He was an APA president. I ask people in my ethics class to imagine a woman laying in bed, and her therapist is sitting next to her bed, and stroking her hair. He tells her, "I love you", and she tells him, "please don't stop". When I ask people in my class what comes to mind, everybody thinks it is unethical, illegal, and he should lose his license because it is sexual, etc. Imagine this scene to be in the therapist's office. In standard therapy she is laying on a bed and he is stroking her hair, and tells her "I love you", but you take this scene and take it to the hospital, imagine she has had cancer for five years, she was told she has two days to live before she dies. She invites the therapist of the last six or seven years to come to say goodbye. She is laying in a hospital bed, he is stroking her hair. He tells her, crying with tears in his eyes, "I love you", and she says, "please don't stop". What is not appropriate in one context may be highly appropriate in another context. You mentioned before, what is the context, what setting, you work with adolescents, do you do high five, do you do adventure therapy and sleep in the same tent. . . courses, you have a lot of touch and holding. I have played basketball when it was appropriate with a reluctant teenage patient, when nothing else would reach him, except playing on a court. It was physical, it was another form of touch. It was playful touch. You are absolutely right, touch can be

understood only within its context. And absolutely clear between supervisees and supervisors, in clients and supervisees, any psychotherapeutic relationship, sexual touch is always unethical and illegal.

Ms. Nordmarken: Ofer, what are some of the more important considerations for touch in therapy.

Dr. Zur: I think what we just talked about. The client's gender, age, client history, setting of therapy, nature of the relationship, therapist attitude towards touch, the methodology being used, the client's inclination to sexualize, I wouldn't play basketball with a teenage girl or teenage boy who is highly attracted to me, I would not necessarily introduce any kind of touch. I need to know the difference.

Ms. Nordmarken: Are you ready to shift gears not to the next boundary? Out of Office?

Dr. Zur: Yes, we will have to do it fast because our time is running out.

Ms. Nordmarken: I am sure it has a lot to do with particular situations, populations, conditions, and settings that require leaving the office. What are some of these.

Dr. Zur: There are many reasons to leave the office, and what I call out of office experience. . . they are part of the treatment plan. That means, if I do fear of flying, or work with agoraphobic, or go to an anorexic lunch, this is part of the treatment plan. It is not dual relationship, it just leaving the office. Then there are home visits for bed ridden patients, or a hospital visit. Home visits are becoming huge right now with the aging population. It has become a standard of millions being treated via home visit. Equine visits are done outside the office, adventure therapy of course, and treating the homeless on the street. All of this therapy takes place outside the office, again, not dual relationship, but what I call, an out of office experience. Then there is a third type of out of office experience. You attend a graduation

of your supervisee or your client, or if your client is an architect, you take a tour of the garden that he or she created, attend a school play of a shy client. Then is the issue of dual relationships, you bump into your supervisee or you're in the community, that can create dual relationship in a small community. Then we have accidental encounters, that are very common on college campuses, military bases, and small communities. So in brief, it is important for the supervisor to make sure the supervisor are open to guide the supervisees, through out of office experience without calling it dual relationship, which it is not, without calling it unethical, because it is a very important form of therapy. Many clients can only receive this type of care outside the office. I wish I could talk more about it but it seems ....

Ms. Nordmarken: Can you touch on some of the more potential advantages outside the office, or does that pretty well cover it?

Dr. Zur: I think it is covered because if you have a bed ridden client, the only way you can reach them is by out of office visit or by telehealth. That is another boundary that we won't have a chance to talk about. There is a hugely growing way of delivering supervision, which is definitely a boundary issue. Teleconferencing, emails, voice, phone, etc. The delivery of telehealth will also be covered in this course

of supervision and boundaries. We have a whole section on Cyber Supervision, the delivery of supervision via telehealth and digital means.

Ms. Nordmarken: Ofer, I want to thank you so much for everything you have shared with us today. In closing is there anything you would like to add?

Dr. Zur: I would like to say to supervisors, take your supervisees as a precious learning curve, and with very little rigidity, hold them to this journey of learning to be flexible, to be thoughtful, to be caring, and to be human. as they do therapy. If you have done this as a supervisor, you have really achieved your goal, and of course, ethically and clinically competent.

Ms. Nordmarken: Thank you so much Dr. Zur.

Dr. Zur: More than welcome.