

2. ETHICS II

2.1 Ethics of therapy setting boundaries between patient and therapist:

"Role boundaries may be crisp or flexible or fuzzy, depending on the role under consideration and on the cultural climate."

-Ingram

The concept of boundaries, particularly in the sense of boundary crossings and boundary violations, has come under increased scrutiny in relation to the wave of sexual misconduct cases arising in litigation, ethics committee hearings, and complaints to boards of licensure. Like many concepts in psychotherapy, such as "therapy," "transference," and "alliance," the term proves slippery on closer observation. The literature tends to focus on patient-therapist sexual misconduct as an extreme violation and not on the wide variety of lesser and more complex boundary crossings, many of which are, at first glance, less obvious but pose difficulties of their own for clinicians.

Clinicians tend to feel that they understand the concept of boundaries instinctively, but using it in practice or explaining it to others is often challenging. This latter problem is rendered more difficult by the tendency of the legal system, particularly plaintiffs' attorneys, to apply it mechanistically: any boundary crossing is bad, wrong, and harmful. Empirical evidence suggests that boundary violations frequently accompany or precede sexual misconduct, but the violations themselves do not always constitute malpractice or misconduct or even bad technique. However, modern clinicians should be aware of three principles that govern the relationship among boundaries, boundary crossings, boundary violations, and sexual misconduct.

First, sexual misconduct usually begins with relatively minor boundary violations, which often show a crescendo pattern of increasing intrusion into the patient's space that culminates in sexual contact. A direct shift from talking to intercourse is quite rare; the "slippery slope" is the characteristic scenario. As Gabbard and Simon have pointed out, a common sequence involves a transition from last-name to first-name basis; then personal conversation intruding on the clinical work; then some body contact (e.g., pats on the shoulder, massages, progressing to hugs); then trips outside the office; then sessions during lunch, sometimes with alcoholic beverages; then dinner; then movies or other social events; and finally sexual intercourse. Second, not all boundary crossings or even boundary violations lead to or represent evidence of sexual misconduct.

A clear boundary violation from one ideological perspective may be standard professional practice from another. For example, the so-called "Christian psychiatry movement" might condone the therapist's attendance at a church

service with one or more patients, and various group therapeutic approaches or therapeutic communities may involve inherent boundary violations, as when some behaviorist schools permit hiring patients in therapy to do work in the treatment setting. Bad training, sloppy practice, lapses of judgment, idiosyncratic treatment philosophies, regional variations, and social and cultural conditioning may all be reflected in behavior that violates boundaries but that may not necessarily lead to sexual misconduct, be harmful, or deviate from the relevant standard of care.

Third, despite this complexity, fact finders-civil or criminal juries, judges, ethics committees of professional organizations or state licensing boards-often believe that the presence of boundary violations (or even crossings) is presumptive evidence of, or corroborates allegations of, sexual misconduct.

To summarize the foregoing more concisely, albeit metaphorically, smoke usually leads to fire; one can, however, find smoke where there is no fire, and yet fact finders may assume that where there's smoke, there's fire. This metaphor is not trivial. In a notorious Massachusetts case in which the doctor accused of sexual misconduct was eventually exonerated), the Board of Registration in Medicine, the state licensing authority, noted in the course of the process, "There was an undisputed level of intimacy between the two [patient and doctor] that supports the inference of sexual relations" (transcript of board proceedings, citation withheld). In its language here, the board clearly articulated its "inference" of fire from the "undisputed" presence of smoke. Moreover, recent court decisions suggest a trend toward findings of liability for boundary violations even in the absence of sexual contact. On this basis, the risk-management value of avoiding even the appearance of boundary violations should be self-evident.

This communication has three goals: (1) to review the subject in order to define, describe, and illustrate the range of boundary issues, 2) to demonstrate that crossing certain boundaries may at times be salutary, at times neutral, and at times harmful, and 3) to suggest preventive and reparative measures for clinicians dealing with boundary violations in themselves and their patients.

DEFINITIONS

What is a boundary? Is it too amorphous, protean, and abstract to define at all? Should we take refuge by saying, as St. Augustine was supposed to have said about time, "Time? I know what time is, provided you do not ask me"?

Part of the difficulty encountered in defining appropriate boundaries can be related to the historical tradition that modern therapists have inherited. The great figures in the field gave out mixed messages on the issue. Freud, for example, used metaphors involving the opacity of a mirror and the dispassionate objectivity

of a surgeon to describe the analyst's role, but his own behavior in the analytic setting did not necessarily reflect the abstinence and anonymity that he advocated in his writings. He sent patients postcards, lent them books, gave them gifts, corrected them when they spoke in a misinformed manner about his family members, provided them with extensive financial support in some cases, and on at least one occasion gave a patient a meal.

D.W. Winnicott, another therapist of considerable stature, occasionally took young patients into his home as part of his treatment of them. In Margaret Little's report of her analysis with Winnicott, she recalled how Winnicott held her hands clasped between his through many hours as she lay on the couch in a near psychotic state. On one occasion he told her about another patient of his who had committed suicide and went into considerable detail about his counter transference reactions to the patient. He also ended each session with coffee and biscuits.

These boundary transgressions by highly revered figures have occasionally been cited in ethics hearings as justification for unethical behavior. We wish to stress that these behaviors are no longer acceptable practice regardless of their place in the history of our field.

The problem of the contradiction between what the master therapists wrote and how they actually behaved in the clinical setting was compounded because psychoanalysis and psychotherapy are treatments that occur in a highly private context. The boundaries of the therapeutic relationship and the characteristics of acceptable technique were thus highly subjective and lacked standardization.

BOUNDARIES IN CLINICAL PRACTICE

"Modern technique tends to move from the position from which the analyst's technique is judged according to his purpose to one from which the analyst's technique is judged according to his behavior".

Another approach to defining therapeutic boundaries is to conceptualize a therapeutic frame, i.e., an envelope or membrane around the therapeutic role that defines the characteristics of the therapeutic relationship. The analyst or therapist constructs the elements of the frame partly consciously and partly unconsciously. These elements include the regular scheduling of appointments, the duration of the appointments, arrangements for payment of the fee, and the office setting itself.

Does the patient's role have a boundary? Spruiell has noted that although the frame is deliberately unbalanced, the patient invariably joins the analyst in elaborating the frame. Most clinicians would agree, basing this answer on

recollected violations they have witnessed, such as the patient who refers to the therapist as "Shrinkie" or springs from the chair and tries without warning to sit on the therapist's lap. It is clear, however, that the patient's boundary is a more forgiving and flexible one. The patient cannot be stopped from calling the therapist names, and that is part of the therapeutic process. The patient can be late and that can be discussed, but the therapist should not be late, and so on. In any case the focus here is on the clinician's boundary.

Let us also agree that the role of therapist embraces the structural aspects of therapy in addition to the content; these include time, place, and money, which may, together with other aspects discussed below, represent possible sites for boundary crossings or violations to occur. If this exploration is to be useful, we should adopt the convention that "boundary crossing" is a descriptive term, neither laudatory nor pejorative.

We should also point out that in addition to serving as antecedents to sexual misconduct, some of the areas of boundary crossing may represent ethical violations in and of themselves.

ROLE

Role boundaries constitute the essential boundary issue. To conceptualize this entity, one might ask, "Is this what a therapist does?" Although subject to ideological variations, this touchstone question not only identifies the question of clinical role but serves as a useful orienting device for avoiding the pitfalls of role violations.

A middle-aged borderline patient, attempting to convey how deeply distressed she felt about her situation, leaped from her chair in the therapist's office and threw herself to her knees at the therapist's feet, clasping his hand in both of her own and crying, "Do you understand how awful it's been for me?" The therapist said gently, "You know, this is really interesting, what's happening here-but it isn't therapy; please go back to your chair." The patient did so, and the incident was explored verbally.

Although such limit setting may appear brusque to some clinicians, it may be the only appropriate response to halt boundary-violating "acting in" (especially of the impulsive or precipitous kind) and to make the behavior available for analysis as part of the therapy.

Almost all patients who enter into a psychotherapeutic process struggle with the unconscious wish to view the therapist as the ideal parent who, unlike the real parents, will gratify all their childhood wishes. As a result of the longings stirred up by the basic transference situation of psychotherapy or psychoanalysis, it is

imperative that some degree of abstinence be maintained. However, strict abstinence is neither desirable nor possible, and total frustration of all the patient's wishes creates a powerful influence on the patient in its own right.

In attempting to delineate the appropriate role for the therapist vis-a-vis the patient's wishes and longings to be loved and held, it is useful to differentiate between "libidinal demands," which cannot be gratified without entering into ethical transgressions and damaging enactments, and "growth needs," which prevent growth if not gratified to some extent.

Even when therapists feel as though they are being coerced into a parental role by their patients, they must strive not to conform to the patients' expectations. Spruiell made the following observation: "It is as disastrous for analysts to actually treat their patients like children as it is for analysts to treat their own children as patients"

TIME

Time is, of course, a boundary, defining the limits of the session itself while providing structure and even containment for many patients, who derive reassurance because they will have to experience the various stresses of reminiscing, reliving, and so forth for a set time only. The beginnings and endings of sessions-starting or stopping late or early-are both susceptible to crossings of this boundary. Such crossings may be subtle or stark.

A male psychiatrist came in to the hospital to see his female inpatient for marathon sessions at odd times, such as from 2:00 to 6:00 in the morning, rationalizing that this procedure was dictated by scheduling problems. This relationship eventually became overtly sexual.

An interesting prejudice about violating the boundary of time has evolved in sexual misconduct cases, a prejudice deriving from the fact that a clinician interested in having a sexual relationship with a patient might well schedule that patient for the last hour of the day (although, of course, after-work time slots have always been popular). In the fog of uncertainty surrounding sexual misconduct (usually a conflict of credibility's without witnesses), this factor has gleamed with so illusory a brightness that some attorneys seem to presume that because the patient had the last appointment of the day, sexual misconduct occurred! Short of seeing patients straight through the night, this problem does not seem to have a clear solution.

PLACE AND SPACE

The therapist's office or a room on a hospital unit is obviously the locale for almost all therapy; some exceptions are noted. Exceptions usually constitute

boundary crossings but are not always harmful. Some examples include accompanying a patient to court for a hearing, visiting a patient at home, and seeing a patient in the intensive care unit after an overdose or in jail after an arrest.

MONEY

Money is a boundary in the sense of defining the business nature of the therapeutic relationship. This is not love, it's work. Indeed, some would argue that the fee received by the therapist is the only appropriate and allowable material gratification to be derived from clinical work. Patient and clinician may each have conflicts about this distinction, but consultative experience makes clear that trouble begins precisely when the therapist stops thinking of therapy as work.

On the other hand, most clinicians learned their trade by working with indigent patients and feel that some attempt should be made to pay back this debt by seeing some patients for free—a form of "tithing," if you will. Note that this decision—to see a patient for free and to discuss that with the patient—is quite different from simply letting the billing lapse or allowing the debt to mount. The latter examples are boundary crossings, perhaps violations.

GIFTS, SERVICES, AND RELATED MATTERS

A client became very upset during an interview with her therapist and began to cry. The therapist, proffering a tissue, held out a hand-tooled Florentine leather case in which a pocket pack of tissues had been placed. After the patient had withdrawn a tissue, the therapist impulsively said, "Why don't you keep the case?" In subsequent supervision the therapist came to understand that this "gift" to the patient was an unconscious bribe designed to avert the anger that the therapist sensed just below the surface of the patient's sorrow.

This gift was also a boundary violation, placing unidentified obligations on the patient and constituting a form of impulsive acting in. A related boundary violation is the use of favors or services from the patient for the benefit of the therapist, as Simon's startling vignette illustrates:

Within a few months of starting . . . psychotherapy, the patient was returning the therapist's library books for him "as a favor." . . . The patient began having trouble paying her treatment bill, so she agreed—at the therapist's suggestion—to clean the therapist's office once a week in partial payment The patient also agreed to get the therapist's lunch at a nearby delicatessen before each session.

CLOTHING

Clothing represents a social boundary the transgression of which is usually inappropriate to the therapeutic situation, yet a patient may appropriately be asked to roll up a sleeve to permit measurement of blood pressure. Excessively revealing or frankly seductive clothing worn by the therapist may represent a boundary violation with potentially harmful effects to patients, but the issue can also be overdone, as in the following case.

A patient in a western state, as part of a sexual misconduct allegation that a jury later found to be false, accused the therapist (among other things) of conducting therapy sessions with the top two buttons of his shirt undone. While such a phenomenon might conceivably represent a violation for a very sensitive patient, evidence was introduced that revealed the exaggerated nature of this claim in this case.

Berne noted the technical error of the male clinician who, confronting a patient whose skirt was pulled up high, began to explain to the patient his sexual fantasies in response to this event. Berne suggested instead saying to the patient, "Pull your skirt down." Similar directness of limit setting appears to be suited to the patient who--either from psychosis or the wish to provoke--begins to take off her clothes in the office. As before, the comment, "This behavior is inappropriate, and it isn't therapy; please put your clothes back on," said in a calm voice, is a reasonable response.

LANGUAGE

As part of the otherwise laudable efforts to humanize and demystify psychiatry a few decades back, the use of a patient's first name was very much in vogue. While this may indeed convey greater warmth and closeness, such usage is a two-edged sword. There is always the possibility that patients may experience the use of first names as misrepresenting the professional relationship as a social friendship. There may well be instances when using first names is appropriate, but therapists must carefully consider whether they are creating a false sense of intimacy that may subsequently backfire.

SELF-DISCLOSURE AND RELATED MATTERS

Few clinicians would argue that the therapist's self-disclosure is always a boundary crossing. Psychoanalysis and intensive psychotherapy involve intense personal relationships. A useful therapeutic alliance may be forged by the therapist's willingness to acknowledge that a painful experience of the patient is familiar to himself. However, when a therapist begins to indulge in even mild

forms of self-disclosure, it is an indication for careful self-scrutiny regarding the motivations for departure from the usual therapeutic stance.

Gorkin observed that many therapists harbor a wish to be known by their patients as a "real person," especially as the termination of the therapy approaches. While it may be technically correct for a therapist to become more spontaneous at the end of the therapeutic process, therapists who become more self-disclosing as the therapy ends must be sure that their reasons for doing so are not related to their own unfulfilled needs in their private lives but, rather, are based on an objective assessment that increased focus on the real relationship is useful for the patient in the termination process. Self-disclosure, however, represents a complex issue.

Clearly, therapists may occasionally use a neutral example from their own lives to illustrate a point. Sharing the impact of a borderline patient's behavior on the therapist may also be useful. The therapist's self-revelation, however, of personal fantasies or dreams; of social, sexual, or financial details; of specific vacation plans; or of expected births or deaths in the family is usually burdening the patient with information, whereas it is the patient's fantasies that might best be explored.

PHYSICAL CONTACT

To place the issue of physical contact in context, it should be noted that psychiatrists traditionally performed their own physical examinations. This practice has declined so markedly that a senior psychiatrist recently wrote about examining a patient's bruised leg as a major return to the past. Hospitals commonly use internists for this purpose. Psychiatric residents still do their own physical examinations but commonly maintain distance by examining each other's patients. Abnormal Involuntary Movement Scale examinations for tardive dyskinesia are often the only routine physical contact.

There is room here for regrets. Physicians working with a patient with AIDS or HIV seropositivity often describe wishing to touch the patient in some benign manner (pat the back, squeeze an arm, pat a hand) in every session. They reason that such patients feel like lepers, and therapeutic touch is called for in these cases. But even such humane interventions must be scrutinized and, indeed, be documented to prevent their misconstruction in today's climate.

CONCLUSIONS

Boundary crossings may be benign or harmful, may take many forms, and may pose problems related to both treatment and potential liability. The differences in impact may depend on whether clinical judgment has been used to make the decision, whether adequate discussion and exploration have taken place, and whether documentation adequately records the details.

The complexity of the subject and the variability of results from case-by-case analysis merit empirical study. Educational materials are available through the Office of Public Affairs of the American Psychiatric Association. Heightened awareness of the concepts of boundaries, boundary crossings, and boundary violations will both improve patient care and contribute to effective risk management.