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Boundary Violations

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The Frame and Its Boundaries

The relationship between the psychiatrist and the patient is special. This unique relationship has been evolving over the past 150 years. It started in the nineteenth century when our forebears, the Alienists, cared for patients in the large public and private asylums, hospitals, retreats, sanatoriums, and prisons. With the insights of Freud and others, more psychiatrists began to see patients privately, and the principles derived from dynamic psychotherapy and psychoanalysis greatly influenced the relationship that psychiatrists had with their patients. This distinct relationship was not only unique as between people in general, it was also unique even among other physicians. Even so, the guiding ideals can be traced to the early behavioral and ethical codes of the ancient physicians. The Hippocratic oath lays the groundwork for the overarching principle of altruism. It suggests that the physician practice in a manner that benefits the patient and not gossip about and not exploit the patient.

In attempting to consolidate the ancient ideas of altruism and the modern ideas of unconscious memories, affects, and motivations, Langs (1977) proposed the concepts of the therapeutic frame and Gabbard and Lester (1995) have illuminated the concepts of therapeutic boundaries.

Langs advised us that psychotherapy occurs within a frame that sets the boundaries of the therapeutic relationship. One part of the frame is composed of the mutually agreed upon constants of the relationship. These constants include the absence of physical contact, confidentiality, constant place of the meeting (e.g., the doctor's office),



payment of a constant fee, and length and frequency of the sessions. The other part of the frame is composed of the human elements of the therapeutic situation and include nonjudgmental acceptance by the therapist, an effort to understand the meaning of communications and behaviors, relative anonymity of the therapist, the agreement by the patient to say whatever comes to mind, abstinence from inappropriate gratifications, offering appropriate gratifications, offering concern and efforts to understand, interpretations of unconscious conflicts as they become apparent, and a particular focus on understanding the interaction between psychiatrist and patient (Gabbard and Lester 1995).

Psychoanalytic thinking has given us abundant boundaries to consider. For example, there are boundaries between the conscious and the unconscious; the psychic and the somatic; the ego, the id, and the superego; the patient and the doctor; the patient's unconscious and the doctor's unconscious; the me and the not-me; sleep and wakefulness; the self and the object; and the internal object and the external object. In ethical terms, there are (or should be) boundaries between, for example, the professional relationship and a social relationship, the professional relationship and a sexual or romantic relationship, the professional relationship and a business relationship, and the professional relationship and a caretaking relationship by the patient. Any passage over the boundary between the professional relationship and any of the other classes of relationships can be called a *boundary crossing*. A serious boundary crossing may be termed a *boundary violation*. This chapter draws attention to the presence of boundaries and the possibilities of boundary crossings and violations and, by doing so, tries to minimize them.



Boundary Crossings

The psychiatrist's office is on the twentieth floor of an office building. The mail slot has been jammed for several days. The doctor asks a patient to mail a letter for him on the way out, saving him a long round-trip on the elevator. *That is certainly a boundary crossing between the professional relationship and caretaking relationship. Is it also a boundary violation? That all depends. Is the envelope a payment to the telephone company or a statement to another patient? The issue of confidentiality comes up. Is it a communication to a brokerage house? What fantasies are stimulated by such an envelope?*

A patient asks for an aspirin for a headache. The doctor happens to have a bottle for her own use. *Does giving the aspirin cross a boundary? Does it violate a boundary?*

A patient mentions that a company he knows of is going to be taken over by a larger company, and its stock will surely go through the roof. *May the doctor inquire as to the name of the company? May he quietly buy some of the stock? What are the boundary issues here?*

Sexual Boundary Violations

The oldest specific admonition for physicians involves abstaining from sexual involvement with patients. Hippocrates, in the fifth century B.C.E., wrote:

Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of freemen and slaves.

Whether Hippocrates was aware of transference or countertransference is unknown. He was, however, keenly aware that a sexual relationship was incompatible with the trust that was necessary for a physician to inspire. Various other portions of the Hippocratic oath have been discarded (e.g., cutting for the stone), but this particular item has remained and is the one admonition that all physicians and almost all laypersons recognize.

Thus, for the past 2,500 years, sexual activity with a patient has been forbidden by our own oath. It was not until 1973 that the American Psychiatric Association first published *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*, which included the phrase: "Sex with a current patient is unethical. Sex with a former patient is almost always unethical" (American Psychiatric Association 1973, p. 4).

In 1993 the American Psychiatric Association Board of Trustees approved a revision of that annotation. In all iterations of the *Principles* published since then, the statement is now absolutely unequivocal and reads, "Sexual activity with a current or former patient is unethical" (American Psychiatric Association 2001, Section 2, Annotation 1).

But it is more complicated than that. Sexual activity with the mother (or father) of a child patient is similarly unethical. This would apply to close relatives and caregivers of patients as well.



The overarching principle is that we must have only one kind of relationship with a patient—that is, a doctor–patient relationship. Dual relationships are fraught with danger for patients and for ourselves. Further, we understand that it would be impossible for a patient to give informed consent to such a relationship because of unconscious transferences that are bound to occur. Sexual involvement, then, is an exploitation of a patient’s primitive feelings, and thus an exploitation of the patient.

The Slippery Slope

In a large majority of cases involving sexual contact with patients and that are brought to ethics committees, a familiar pattern emerges. The sexual activity does not occur in a vacuum. Sex does not happen in an unguarded moment of mutual passion. There are hints and precursors. Often, we hear of seemingly innocuous boundary crossings. A cup of coffee together. A ride home. A hug. A squeeze of the hand. A longer hug. A kiss on the cheek. A kiss elsewhere. A shared scheme involving the psychiatrist. Any one of these boundary crossings could be, in and of itself, innocent enough. But when they become part of a pattern, one must become alarmed. As some of these behaviors occur, there is a shift away from the exclusive professional relationship toward a dual relationship that might include the professional relationship as well as a social or romantic relationship.

Nonsexual Boundary Crossings and Violations

Sexual boundary violations are relatively easy to describe and to exhort against. Nonsexual boundary violations (e.g., crossing the boundary between the professional relationship and the social, business, personal, caregiving, or pseudoparental relationship) are more difficult to describe—and giving strict rules is more difficult.

Self-Disclosure

In the past decade or two there has been a move away from the absolute prohibition of any type of self-disclosure. That absolute prohibition was derived from classical psychoanalytic technique in which the anonymity of the analyst provided a blank screen upon which the analysand could project elements from his or her own unconscious. Even psychiatrists not practicing analysis recognized that telling patients about them-

selves sometimes had the effect of burdening the patient with the doctor's own problems. This tended to add a separate component to the professional relationship, an additional element of the patient becoming a caregiver. Further, some disclosures may be heard by the patient in ways that are unintended by the psychiatrist. For example, a psychiatrist who, with the intent of strengthening rapport with a patient, says "Yes, I can understand how you feel. I never got along with my father either." The patient may hear this in a way that suggests that the doctor is even more flawed than the patient feels himself to be, thus decreasing the rapport.

Yet, there is increasing discussion in analytic as well as in nonanalytic circles about how much and what kind of self-disclosure is appropriate and under what circumstances. The decisions are complex and involve a thorough knowledge of the psychodynamics of the patient and the conscious and unconscious meanings of such disclosure. So, although the frame is changing and the use of self-disclosure is increasing, this situation is fraught with potential problems. The best advice continues to be: *When in doubt, don't.*

Certain types of self-disclosure are certainly inappropriate under any circumstances. These include disclosing the psychiatrist's fantasies concerning the patient, especially those of a sexual nature. Therapists' dreams in general should not be discussed, especially if they have a sexual content and most especially if they involve the patient.

On the other hand, some types of self-disclosure are now felt to be essential. If the doctor has become ill and there is the likelihood that he or she may become disabled or incapacitated, the patient should be told, so that the patient can be helped to decide if continuing with that doctor is in the patient's best interests. This speaks to the issue of patient autonomy and informed consent, both laudable ethical principles. Further, if the psychiatrist has an obvious injury or illness, it is probably better to inform the patient of the nature of the injury rather than allow the patient's fantasy to run away. However, under certain analytic circumstances, self-disclosure of this sort may be contraindicated.

Gifts

The subject of gifts has attracted a considerable amount of attention and is the subject of Chapter 7 of this primer. Other medical specialists are often given gifts, and no particular harm seems to result. But psychiatrists are committed to understand all communications, both ver-



bal and nonverbal. The giving and receiving of gifts is certainly the type of communication that deserves our attention. Does the patient feel that a gift must be given? How does the patient get such an idea? Is the psychiatrist's office filled with wrapped presents during the holidays? If so, what does that tell the next patient who comes through the door? Many psychiatrists feel it is appropriate to accept small gifts at the holiday season with little or no interpretation. Expensive or suggestive gifts should be declined with whatever explanation or interpretation is appropriate.

Physical Contact

In the not too distant past, psychiatric residents were prohibited from touching their patients in any way. If some contact became necessary, for example, taking the pulse or blood pressure, another resident was asked to do it. Such prohibitions are quite rare now, but thoughtful precautions should be taken before touching a patient. One of the most common problems is that the patient might experience the touch in a way that is quite different from the way the doctor offered it. An avuncular hug from a kindly senior psychiatrist may be experienced as the prelude to a sexual or romantic shift. Certain patients are more inclined to such misinterpretations than are others. Everything considered, it is best to avoid physical contact. Yet problems can occur when touching is avoided.

A male patient was in analysis with a male analyst. When the psychiatrist opened the waiting room door to bring the patient into the consulting room, the patient would extend his hand to shake the psychiatrist's hand. This practice had gone on for many months. One day the psychiatrist opened the waiting room door and saw the patient, who had a bad cold, wiping his nose with his hand. As the patient extended his hand, the doctor pulled back his own hand. The patient perceived this as a severe rejection of himself (as opposed to the germs), and the doctor suffered through many hours of diatribe and vituperation. *In retrospect, perhaps the daily handshake should have been examined earlier for its meaning of acceptance by the doctor for the patient.*

A male psychiatrist treated a female patient for several years in weekly psychotherapy. Numerous seriously traumatic events befell the patient during that time, and the psychiatrist was supportive. They had gone through a lot together. It came time to terminate the treatment, and the termination was worked through. At the last session, both got

up, and the doctor opened the door for the patient. As the patient went by the doctor, she stopped and gave him a spontaneous hug. The doctor froze and did not reciprocate. The patient instantly recognized the doctor's predicament and laughed as she pointed out that she certainly felt freer than he did. He felt bad that, indeed, he did not feel free to give an appropriate human response.

Confidentiality

Confidentiality, a major issue in the containment of boundaries, is discussed in Chapter 6 of this primer.

Financial Relationships

Financial relationships with patients clearly form a separate and distinct class of relationship and, with the exception of the circumstances surrounding the agreed-upon fee, are to be avoided. One should not hire one's patients or their relatives to do work, even if the work to be performed benefits both the doctor and the patient.

A psychiatrist hires a patient to do some electrical work on his house. Should the fee be based on the hourly rate of the psychiatrist or of the electrician? If the rates are different, one or the other may be resentful. If there is a problem with the work, should the doctor bring it up with the patient during the session or call him in the evening? If a dispute occurs, how can it be resolved without interfering with the treatment?

A patient invites her psychiatrist to become a partner in a business venture. The doctor is flattered and accepts. The doctor takes on more and more responsibility and buys more and more stock until she controls the board and the company. The patient feels preempted by the psychiatrist and brings a lawsuit. This can have serious consequences for the treatment!

A barter arrangement is tempting to consider for the patient who cannot afford the psychiatrist's regular fee. However, there are a number of problems here. First, unless both parties to the barter arrangement report the value of the services received as income, the barter is illegal. In addition, numerous problems may occur, as with the financial relationship cited earlier. How will the barter be constructed? One hour of therapy for one hour of baby-sitting? One hour of therapy for 20 hours of baby-sitting? What happens if the work is not acceptable? Is this grist for the mill, or should it be settled in a different way? Who has the power? Who needs to please whom and why? It is certainly a lot



cleaner for the patient to do his or her work and pay the doctor for the doctor's work.

Information

As noted earlier, using information such as data on a financial deal crosses the boundary between professional relationships and business relationships and should be avoided. Other sorts of information that may become available in a treatment situation should similarly not be taken out of the office or used in any way. This would include, in addition to stock tips, information about the patient's financial status; information about the financial or other aspects of the patient's family, friends, and associates; and political information. These boundaries merge with the area of confidentiality, which proposes that whatever information is brought forward in the office stays in the office. As Hippocrates advised:

Whatever, in connection with my professional practice or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.

Autonomy

In the past few decades, there has been a shift in medical ethics away from paternalism and toward autonomy. The doctor does not always know best, and further, an informed and competent patient ought to be able to make his or her own decisions. Good clinical practice alone would dictate that fostering adult behavior in adults is better than infantilizing them. It is not uncommon for psychiatrists to be quite directive with some patients. One must be certain that this directiveness is in the best interests of the patient and does not fulfill some need of the psychiatrist. As an example, suggesting that a patient go into the field of medicine may be in the interests of the patient, but it also may derive from the doctor's wish to control or to have a disciple. It may be a displacement from the doctor's wish that his or her own child go into medicine.

Influences

Similarly, the psychiatrist should avoid influencing the patient in any way not directly relevant to treatment goals. This would obviously in-

clude attempts to persuade the patient in religious matters, in matters concerning sexual orientation, and in political circumstances. From time to time, psychiatrists feel a moral duty to address these concerns with their patients. If one cannot resist such temptations, supervision should be sought or the patient transferred to another psychiatrist.

Recently there has been a temptation to engage patients in social and political matters that might aid patients generally. Extreme care must be taken to ensure that it is not the doctor's own interests that are at work.

Our nonpsychiatric medical colleagues are occasionally involved in fund-raising activities on behalf of their hospital, medical school, or charity. It is not uncommon for them to solicit contributions from their grateful patients. Psychiatrists should avoid participating in such activities, because doing so often relies on unresolved transference feelings and thus exploits the patient. If a former patient wishes to show his or her gratitude by making an unsolicited gift to an organization, such a patient should be directed to the development specialist at the organization or to an otherwise uninvolved colleague who will assist with the donation.

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