

Treatment Boundary Violations: Clinical, Ethical, and Legal Considerations

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The observance of treatment boundaries maintains the integrity of the therapist-patient relationship. It is the therapist's professional duty to establish appropriate treatment boundaries. Basic boundary guidelines are reviewed. The principles underlying these boundary guidelines are explored. A clinical vignette describing the sexual exploitation of a patient by her therapist dramatically illustrates progressive boundary violations. Boundary violations involving money are particularly common. Double agent roles also are likely to lead to the establishment of dissonant treatment boundaries with patients. The clinical, ethical, and legal issues surrounding the maintenance of treatment boundaries are discussed.

The concept of treatment boundaries developed during the twentieth century from outpatient psychodynamic psychotherapy. Treatment boundaries have been a continuing issue since the beginning of psychoanalysis, reflected in Freud's disputes, for example, with Ferenczi and Reich. Ethical principles developed by the mental health professions and the legal duties imposed by courts and statutes have further defined treatment boundaries. For example, the clinician's duty to maintain confidentiality derives from three distinct origins: professional (clinical), ethical, and legal.

Treatment boundaries are set by the therapist that define and secure the therapist's professional relationship with the

patient for the purpose of promoting a trusting, working alliance. The boundary guidelines listed below are generally applicable to the broad spectrum of psychiatric treatments. Nevertheless, considerable disagreement exists among psychiatrists concerning what constitutes treatment boundary violations. The therapy techniques of one therapist may be anathema to another therapist who considers such practices as clear boundary violations. Much variability in defining treatment boundaries appears to be a function of the nature of the patient, the treatment and the status of the therapeutic alliance. For example, notable exceptions do occur in alcohol and drug abuse programs, in inpatient settings and with certain cognitive-behaviorally based therapies. Regardless of the therapy used, every therapist must maintain basic treatment boundaries

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with all patients. If boundary exceptions are made, they must be made for the benefit of the patient. Every effort must be exerted to therapeutically restore breached boundaries. Brief boundary violations that are quickly recognized and rectified can provide important insights into conflictual issues for both the therapist and patient. The danger to treatment arises when boundary violations progress in frequency and severity over time.

Since boundary guidelines maintain the integrity of therapy and safeguard both the therapist and the patient, proponents of therapies that breach generally accepted boundary guidelines risk harming the patient and suffering the legal consequences.¹ Psychiatry continues to be highly receptive to innovative treatments that offer the hope of helping the mentally ill. The maintenance of basic treatment boundaries, by itself, should not be an impediment to therapeutic innovations. On the contrary, conducting innovative therapies in general accord within accepted treatment boundaries should provide added credibility.

Psychotherapy as an Impossible Task

All psychiatric therapies, regardless of their philosophical or theoretical orientation, are based upon the fundamental premise that interaction with another human being can alleviate psychic distress, change behavior, and alter a person's perspective of the world.² Psychotherapy can be defined as the application of clinical knowledge and skill to the

dynamic psychological interaction between two people for the purpose of alleviating mental suffering. This definition of psychotherapy also applies to biological and behavioral therapies. But psychotherapy is an impossible task.¹ There are no perfect therapists nor perfect therapies.

Psychotherapy also has been defined as a mutually regressive relationship with shared tasks but different roles.³ Boundary violations are therapist role violations that inevitably occur to a degree in every therapy. Although maintaining boundaries is a major psychotherapeutic imperative, the competent psychotherapist must recognize when he or she has erred. Often, the real work of psychotherapy involves the therapeutic restitution of breached boundaries. Treatment boundaries usually can be reestablished if the therapist can raise the boundary violation as a treatment issue. Since therapists use themselves as a therapeutic tool, sensitivity to boundary violations must be maintained at a high level.

From a clinical perspective, the therapeutic alliance is considered by most practitioners to be the single most critical factor associated with successful treatment.⁴ The maintenance of treatment boundaries sets the foundation for the development of the therapeutic alliance and the subsequent work of therapy. Trust is the essential basis for a secure therapeutic relationship that permits patients to reveal their innermost yearnings and fears. The patient's trust is based upon the belief that the therapist is acting professionally and using skills

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in a competent manner for the benefit of the patient. The maintenance of consistent, stable, and enabling treatment boundaries creates a safe therapeutic environment for the patient to risk self-revelation. At base, the therapist's professional concern and respect for the patient ensures that treatment boundaries will be preserved.

Treatment boundary violations occur on a continuum that may interfere with the provision of competent clinical care to the patient. Boundary violations frequently are a consequence of the therapist acting out personal conflicts. As a result, the patient's diagnosis may be missed. Inappropriate treatment may be rendered. Moreover, the patient's original psychiatric condition may be worsened. Boundary violations may represent deviations in the standard of care that are alleged to have harmed the patient, forming the basis of a malpractice claim. Boundary violations as an integral part of negligent psychotherapy are inevitably present in claims of sexual misconduct as in well as other types of suits alleging exploitation of patients.

Boundary violations also encourage malpractice suits by creating a misalliance between therapist and patient. Boundary violations, usually reflecting the personal agenda of the therapist, set patient and therapist against one another. Langs⁵ notes that the failure to maintain treatment boundaries may lead to autistic, symbiotic, and parasitic relationships with patients. Langs observes that autistic relationships (severed link) between therapist and patient damage meaningful relatedness, symbiotic

(fusional) relationships pathologically gratify the patient, and parasitic (destructive) relationships exploit the patient. As frequently happens, bad results combined with bad feelings set the stage for a malpractice suit.⁶

Basic Boundary Guidelines

Treatment boundaries are set by the therapist according to accepted professional standards. It is the therapist's professional duty to establish and maintain appropriate treatment boundaries in the provision of good clinical care. This duty cannot be delegated to the patient. Once treatment boundaries are established, boundary issues inevitably arise in working with the patient that form an essential aspect of treatment. Boundary *violations*, on the other hand, arise solely from the therapist and are often inimical to treatment, particularly if unchecked and progressive. Therapists who establish idiosyncratic boundaries or set no boundaries at all are likely to provide negligent therapy that harms the patient and invites a malpractice suit. A major continuing task for therapists is the maintaining of constant vigilance against boundary violations and immediately repairing any breaches in a clinically supportive manner.

Observing the following boundary guidelines for psychotherapy will help maintain the integrity of the treatment process:

- Maintain relative therapist neutrality
- Foster psychological separateness of patient
- Protect confidentiality

- Obtain informed consent for treatments and procedures
- Interact verbally with patients
- Ensure no previous, current, or future personal relationship with the patient
- Minimize physical contact
- Preserve relative anonymity of therapist
- Establish a stable fee policy
- Provide consistent, private, and professional setting
- Define time and length of sessions.

These guidelines will be discussed more fully later in connection with a clinical vignette.

Some of these guidelines have been considered by Langs⁷ to form a necessary treatment frame for the conduct of psychodynamic psychotherapy. Although additional boundary rules can be elaborated, a consensus generally exists concerning the basic rules listed above. Other rules concerning the management of transference and countertransference could be included but might not find ready acceptance among some behaviorists, biological psychiatrists, and “here and now” treatments such as Gestalt therapy. Nevertheless, regardless of theoretical orientation, all therapists must recognize that transference and countertransference plays an important role in any therapy.

An absolutist position concerning treatment boundary guidelines cannot be taken. Otherwise, it would be appropriate to refer to boundary guidelines as boundary standards. Effective treatment boundaries do not create walls that separate the therapist from the patient. In-

stead, they define a fluctuating, reasonably neutral, safe space that enables the dynamic, psychological interaction between therapist and patient to unfold. Since treatment boundaries have a certain variability, unanimity of professional opinion does not exist on a number of boundary issues. Moreover, practitioners may place a different emphasis on certain boundary guidelines. Although the static listing of boundary guidelines serves an important heuristic purpose, clinicians must remain vigilant to the *process* of gradual, progressive boundary violations. Progressive boundary violations are almost invariably the consequence of an exploitative relationship established by the therapist with the patient.

Principles Underlying Boundary Guidelines

Rule of Abstinence There are a number of basic, overlapping principles that form the underpinning for the establishment of boundary guidelines. One of the foremost principles is the rule of abstinence, which states that the therapist must refrain from obtaining personal gratification at the expense of the patient.⁸ Extra-therapeutic gratifications within treatment must be avoided by both therapist and patient.⁷

A corollary of the principle of abstinence states that the therapist's main source of personal gratification arises from the professional gratification derived from the psychotherapeutic process and the satisfactions gained in helping the patient. The only material satisfaction directly received from the

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patient is the fee for the therapist's professional services. Treatment boundaries are violated when the primary source of the therapist's gratification is received *from* the patient directly rather than through engagement in the therapeutic process *with* the patient. The principle of abstinence underlies virtually all boundary guidelines.

Duty to Neutrality The rule of abstinence attempts to secure a position of neutrality for the therapist's interactions with the patient. Therapeutic neutrality is not defined here in the psychoanalytic sense of equidistance between the patient's ego, superego, id, and reality. Rather, it means knowing one's place and staying out of the patient's personal life.⁹ Therapeutic neutrality allows for the patient's agenda to be given primary consideration. The relative anonymity of the therapist ensures that self-disclosures will be kept at a minimum, thus maintaining therapist neutrality. Also, the law independently recognizes the therapist's duty of neutrality toward patients.¹⁰

The concept of relative neutrality refers to the limitations imposed upon psychotherapists from interfering in the personal lives of their patients. Life choices such as marriage, occupation, where one lives, and with whom one associates, while grist for the therapeutic mill, are fundamentally the patient's final choice.¹¹ Nor should the personal views of the therapist concerning politics, religion, abortion, and divorce, for example, be aired in the treatment situation.

If an otherwise competent patient is

contemplating making a decision that appears foolish or even potentially destructive, the therapist's role is limited primarily to raising the questionable decision as a treatment issue. For example, the therapist can appropriately explore the psychological meaning of the decision as well as its potential adverse consequences on the patient's treatment and life situation. On the other hand, situations do arise with patients when the psychotherapist must intervene directly. If a patient's decision-making capacity is severely compromised by a mental disorder, the therapist may need to actively intervene to protect the patient or others.¹² As an obvious example, a psychotically depressed, suicidal patient who refuses to enter a hospital voluntarily will likely require involuntary hospitalization. Under these conditions, the therapist is intervening in the patient's life for valid clinical, not personal, reasons.

Patient Autonomy and Self-Determination Fostering the autonomy and self-determination of the patient is another major principle underlying treatment boundary guidelines. Sustaining patient separateness through the process of separation-individuation follows as a corollary. Of the over 450 psychotherapies currently available, none state as their long-term treatment goal that patients should remain dependent and psychologically fused with their therapists or others. Obtaining informed consent for proposed procedures and treatments also preserves the autonomy of the patient.¹³

Patient self-determination requires

that the therapist's clinical posture toward the patient should be expectant. That is, the patient basically determines the content of his or her sessions. Generally, this does not apply in cognitive behavioral therapies or even with some forms of interpersonal therapy. Moreover, the stricture that physical contact with patients be essentially avoided and that the therapist stay out of the persons personal life (no past, current, or future personal relationships) derive in large measure from the principle of autonomy and self-determination.

Progressive boundary violations invariably limit the patient's freedom of exploration and choice. Properly maintained treatment boundaries foster the separateness of the patient from the therapist while also maintaining the psychological relatedness of the patient to others.

Fiduciary Relationship As a matter of law, the physician-patient relationship is fiducial. In *Omer v. Edaren*,¹⁴ a lawsuit was brought against a psychiatrist for alleged sexual exploitation of a patient. The Washington Court of Appeals noted that:

Washington also has characterized the relationship between physician and patient as fiduciary: "The physician-patient relationship is of fiduciary nature. The inherent necessity for trust and confidence requires scrupulous good faith on the part of the physician" (citations omitted).

The knowledge and power asymmetries that exist between therapist and patient require the therapist not to use the patient for his or her personal advantage.¹⁵ This responsibility is "implicit" in the therapist-patient relationship and is a

fundamental aspect of the general "duty of care." The special vulnerabilities of the patient rather than the special powers of a profession give rise to a fiduciary duty.¹⁶ A fiduciary relationship arises, therefore, whenever confidence, faith, and trust are reposed on one side, and domination and influence results on the other.¹⁷ Not only psychiatrists but all mental health professionals have a fiduciary responsibility to their patients. The maintenance of confidentiality, privacy, a stable fee policy and consistent time and treatment settings are derived in large measure from the fiduciary duties of the therapist.

Respect for Human Dignity Moral, ethical, and professional standards require that psychiatrists as well as nonmedical professionals treat their patients with compassion and respect. The dedication of physicians to their patients has a long and venerable tradition so artfully expressed in the Hippocratic oath. *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*¹⁸ states: "A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity." On clinical grounds alone, the competent therapist always must strive to maintain the patient's healthy self-esteem during the course of therapy. Exploitative therapists, however, relate to patients as part objects to be used for their own personal gratification. Frequently, such therapists attack the self-esteem of their patients in order to gain control over them. All of the boundary guidelines are substan-

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tially based on the principle of respect for human dignity.

Exigent Boundary Violations

In the course of therapy, it may be necessary for the sake of the patient or the welfare of others for the psychiatrist to cross accepted treatment boundaries. Boundary violations may be driven by crises in clinical care, and by intervening, superseding ethical or legal duties. For example, an agoraphobic patient may be incapacitated and unable to come to the psychiatrist's office. Home visits may be required initially. The potentially violent patient who threatens others places the psychiatrist in a conflicting ethical position regarding maintaining confidentiality. Professional and legal duties to warn and protect endangered third persons, however, may necessitate a breach of the patient's confidentiality. In the latter example, if the patient can be brought into the process of issuing a warning, treatment boundaries may be stretched but not necessarily violated. Engaging patients in the decision to readjust treatment boundaries as a result of treatment exigencies may permit salutary boundary reshaping that actually facilitates the treatment process.

Impaired Therapists

Impaired therapists usually experience great difficulty in establishing and maintaining acceptable treatment boundaries.¹⁹ Deviant, idiosyncratic boundary setting forms the groundwork for patient exploitation. Therapists who suffer from severe character disorders tend to repeat boundary deviations with

a number of their patients. The predatory, exploitative therapist also belongs to this group. Other therapists who establish deviant boundaries may be merely incompetent, impaired by alcohol, drugs, and mental illness, situationally distressed by personal crises, or suffering from a paraphilia, particularly frotteurism. Frotteurs consistently fail to maintain appropriate physical distance from patients, becoming involved in inappropriate touching.

Vulnerable Patients

Every patient, by virtue of being a patient, is vulnerable to psychological damage from therapists who commit boundary violations. Psychotic and borderline patients are particularly at risk for psychic injury.²⁰ Frequently, these patients have been physically and sexually abused as children. Their sense of what constitutes appropriate relationships and boundaries may be seriously impaired. Treatment boundaries are frequently tested by the patient through repetition of early childhood relationships where personal boundaries were not respected. Highly dependent patients or patients recently experiencing a personal loss also are vulnerable to exploitation.

Patients with Borderline Personality Disorder (BPD) present special problems for therapist.²¹ These patients frequently attempt to manipulate and draw the therapist out of the treatment role. Therapists frequently find themselves making exceptions in the treatment of such patients. Patients with BPD often induce the greatest countertransference

trap of all: the desire to do better than or to undo the damage done by, previous parental figures. Thus, a high level of vigilance for treatment boundary violations must be maintained by therapists who treat BPD patients.²² From a litigation perspective, suicide and sexual misconduct are the most common claims in malpractice suits against therapists treating patients with BPD.

Although the therapist sets the treatment boundaries, patients will question or test these boundaries repeatedly and in various ways. Thus, boundary issues invariably arise in every therapy as grist for the therapeutic mill. Generally, healthier patients are able to stay within acceptably established treatment boundaries, using the treatment framework provided to progress psychologically. More disturbed patients often act out their conflicts surrounding boundary issues. For example, a patient who was sexually abused as a child may actively repeat sexually seductive behavior toward the therapist who is attempting to maintain relative anonymity and neutrality. With many of these more disturbed patients, a considerable portion of the therapy is devoted to examining the psychological meaning of the patient's efforts to gain exceptions to established treatment boundaries. Patients who are consistently unable to tolerate limit setting by the therapist may be untreatable.²³

Severely disturbed patients frequently present daunting treatment and management problems for therapists who are willing to undertake their care. The patient's psychiatric condition with the as-

sociated vicissitudes in the therapeutic alliance may necessitate utilizing innovative treatment techniques that cross customary treatment boundaries without necessarily creating deviant boundaries. The strict application of the usual boundary guidelines to these patients could prove inimical to their treatment.

Boundary Violations: Illustration and Discussion

Sexual Exploitation Invariably, in cases of therapist-patient sex, progressive boundary violations precede and accompany the eventual sexual acts.²² Patients are psychologically damaged by the precursor boundary violations in addition to the ultimate sexual exploitation.^{24, 25} Even if the therapist and patient stop short of an overt sexual relationship, precursor boundary violations interfere with the adequate diagnosis and treatment of the patient. Thus, therapists may be sued for negligent psychotherapy in addition to sexual misconduct. Under either circumstance, patients are not provided essential psychiatric care. The patient's original mental disorder is often exacerbated and other mental disorders are iatrogenically induced.

Sexual misconduct cases usually demonstrate boundary violations in the extreme. Thus, their study can be very instructive. The following clinical vignette will be used as an introduction to the discussion of basic boundary guidelines. It illustrates the progressive, increasingly flagrant violation of treatment boundaries that often precede therapist-patient sex:

A 38-year-old single woman with previously

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diagnosed Borderline Personality Disorder and drug abuse seeks treatment for severe depression following a spontaneous abortion. The psychiatrist is 49 years old, and recently divorced by his wife. His ex-wife is a very attractive, talented artist who ran off with a concert pianist. The psychiatrist is increasingly relying on alcohol to deal with his feelings of loss.

The patient is quite bright and attractive. She talks continually about her feelings of isolation and emptiness. Clear vegetative signs of depression are present. The patient had hoped for a child as a way of assuaging her loneliness. The psychiatrist is struck by the patient's resemblance to his ex-wife. He becomes quickly enamored of the patient, overlooking and minimizing her major depression. His clinical judgment is further distorted by the appearance of improvement in the patient's depression as the psychiatrist shows a personal interest in her. The psychiatrist looks forward to seeing the patient for her twice-a-week appointments, finding solace and relief from his own sense of desolation. For the first two months, the treatment boundary remains relatively intact. Then gradually, the sessions take on a conversational, social tone.

Psychiatrist and patient begin to address each other by their first names. The psychiatrist discloses the facts surrounding his divorce, talking at length about his wife's infidelity and his feelings of betrayal. He also confides in the patient intimate details about his other patients, treating her as a confidant. The patient is distressed at the psychiatrist's unhappiness and feels guilty that she cannot be of more assistance. Initially, the psychiatrist sits across from the patient but gradually moves his chair closer. Ultimately doctor and patient sit together on the sofa. Occasionally the psychiatrist puts his arm around the patient when she tearfully describes extensive childhood physical and sexual abuse. Treatment sessions are extended in time, some lasting as long as three hours. The patient feels grateful that she is receiving such special treatment.

Because the extended sessions disrupt the psychiatrist's other appointments, the patient is scheduled for the end of the day. Whenever possible, therapist and patient also meet for brief periods of time at a nearby park or bar for a drink. Because the patient complains of

sleeping problems, the psychiatrist prescribes barbiturates. He has not kept up with developments in psychopharmacology, having used medications very sparingly in his practice over the years. The psychiatrist is unaware of her prior addiction to narcotics. He does not explain the risks of taking barbiturate medications. The patient requires higher doses of barbiturates over time that interfere with her ability to function independently. The psychiatrist begins to make day-to-day decisions for the patient, including balancing her checkbook.

During sessions, therapist and patient begin to embrace and kiss. The psychiatrist finds the patient more compliant to his advances when she has had a few drinks. During one session when the patient drinks too much, sexual intercourse takes place. The psychiatrist stops billing the patient as their sexual relationship continues.

A few months later, the psychiatrist takes an extended vacation. While he is away, the patient learns from another patient that the psychiatrist revealed details of her childhood sexual abuse. The patient becomes extremely depressed and takes a near lethal overdose of barbiturates. While hospitalized, she is weaned from barbiturates. She discloses the fact of her sexual involvement with her outpatient psychiatrist. The patient is successfully treated for major depression with antidepressants. The diagnosis of Borderline Personality Disorder also is made that is severely aggravated due to the sexual exploitation by her therapist. The exploiting psychiatrist attempts to see the patient upon his return. She refuses. One year later, the patient brings a malpractice suit against the psychiatrist for sexual misconduct.

Neutrality and Self-Determination

The rule of abstinence and the therapist position of relative neutrality empower patient separateness, autonomy, and self-determination. In the vignette, the psychiatrist abandons a position of neutrality and undercuts the patient's independence through numerous boundary violations that promote fusion between psychiatrist and patient. He gradually

gains control over the patient's life, making basic life decisions for her. Whether done consciously or subconsciously, boundary violations cut short a patient's options for recovery and independent psychological functioning. The achievement of psychological independence is a goal of treatment. Maintaining patient separateness that permits pursuit of this goal is a boundary issue.

Confidentiality The psychiatrist in the clinical vignette fails to maintain confidentiality. To gain the patient's confidence, he shares intimate information about other patients. This creates the illusion that she is special.

The maintenance of confidentiality is an absolute boundary guideline that must be followed unless specific clinical, ethical, or legal exceptions arise.¹³ Confidentiality must be maintained unless release of information is competently authorized by the patient. Breaches of confidentiality typically occur when therapists are in double agent roles.¹⁶ Such roles occur when the therapist must serve simultaneously the patient and a third party. For example, prison and military mental health professionals frequently find themselves in double agent roles. Clinicians working in managed care settings frequently find themselves also struggling with dual roles.

Informed Consent Although the law requires informed consent for treatments and procedures, informing patients of the risks and benefits of a proposed treatment incidently, but importantly, maintains patient autonomy and fosters the therapeutic alliance.²⁶ In a number of sexual misconduct cases,

drugs and even ECT have been used to gain control over patients.²⁷ Boundary violations concerning medication practices are particularly egregious in these cases. Obviously, no effort is made to inform the patients of the risks and benefits of prescribed medication. Frequently, large amounts of addictive medications are given, particularly barbiturates and benzodiazapines.

In an effort to gain control over the patient, the psychiatrist in the vignette negligently plies her with increasing amounts of barbiturates and alcohol. If the addictive risks of barbiturates had been explained to the patient, her earlier history of narcotic addiction might have been revealed. The psychiatrist, however, is perusing a personal rather than a clinical agenda. Thus, the patient's need for autonomy and self-determination is subjugated to the therapist's desire to make the patient dependent upon him.

Verbal Interaction The process of psychotherapy requires that the interaction between therapist and patient be basically verbal. Engaging the patient verbally tends to check acting out responses by the therapist. In psychotherapy, the therapist must always be alert to the possibility of acting out his or her emotional conflicts with the patient. This can manifest itself either through the therapist's behavior or by inducing the patient to act out.

There is, however, a fundamental difference between active interventions undertaken by the therapist and therapist acting out. For example, when somatic therapies or behavioral modification

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techniques are used, active interventions are made in the service of the treatment, not for the purpose of exploiting the patient. Moreover, therapists frequently find it necessary to actively clinically intervene on behalf of patients in crisis. All therapies, even Rogerian therapy and psychoanalysis, employ active interventions and reinforcement approaches.²⁸ The danger to patients and their therapy does not arise from therapists' activity *per se*, but from therapists' acting out.

Bibring²⁹ pointed out that all dynamic psychotherapies variously utilize catharsis, suggestion, manipulation, clarification, and insight in their therapeutic approaches to the patient. Regardless of the methods favored, the patient should be primarily engaged on a verbal rather than on an action level. Although it is certainly possible for therapists to act out exclusively on a verbal level, the behavioral expressions of emotional conflict by therapists are much more common and damaging to patients. For example, in the clinical vignette, the psychiatrist induces the patient to engage in a host of acting out behaviors including a sexual relationship.

Personal Relationships The specific boundary violations in the hypothetical vignette are, unfortunately, all too common in reality. Even if sex did not take place, the psychiatrist abandons a neutral position and damages the patient. The progressive precursor boundary violations prevented appropriate diagnosis and treatment of the patient's depression, inducing a barbiturate addiction and exacerbating a preexisting Borderline Personality Disorder.

Most therapists accept the boundary guideline principle of no previous, current, or future personal relations with the patient. For a number of sound clinical reasons, post-termination relationships with patients should be avoided.³⁰ Past and current personal relationships with a patient hopelessly muddles treatment boundaries and dooms any therapeutic efforts. The social chit chat that usually ensues is not psychotherapy. Transferences are often timeless, raising serious concerns about a former patient's ability for autonomous consent to a post-termination relationship.

Physical Contact The essential avoidance of physical contact with patients remains a controversial issue.³¹ Occasions may arise in treatment when a handshake or a hug is an appropriate human response. Clinically correct touching often occurs in the course of administering a procedure or treatment. Therapists who work with children, the elderly, and the physically ill frequently touch their patients in an appropriate, clinically supportive manner. An absolute prohibition against touching the patient would preclude such therapeutic human responses and supportive clinical interventions. Obviously, the psychiatrist in the vignette violates the guidelines against a personal relationship with the patient and the essential avoidance of physical contact.

Therapists must be extremely wary of touching patients. Hugging may seem innocuous, but when closely considered, most hugs contain erotic messages. The practice of gratuitously touching the patient is often clinically inappropriate and

may be a prelude to sexual intimacies.³² Holroyd and Brodsky³³ found that non-erotic hugging, kissing, and touching of opposite sex patients but not same sex patients is a sex-biased therapy practice at high risk for leading to sexual intercourse with patients. Every patient has the right to maintain the integrity and privacy of his or her own body.

Some psychiatrists still perform their own physical examinations of patients. The transference and countertransference complications associated with physically examining psychiatric patients are well known. It is very important that a physical examination not become the first step to progressive physical involvement with the patient.

The issue of sex with a terminated patient is a more complicated matter.¹³ The proposal advanced by Appelbaum and Jorgenson³⁴ of a one-year waiting period after termination that "should minimize problems and allow former patients and therapists to enter into intimate relationships" will likely disrupt treatment boundaries from the outset. What deviations in treatment boundaries will occur if, during the course of therapy, the patient is considered to be a potential sexual partner after termination? Will the therapy turn into a tryst and become a courtship? Will the course of therapy be prematurely shortened so as to get to the sexual relationship? For the sake of the patient's treatment, should not the patient be irrevocably and unequivocally renounced as a sexual partner for the therapist from the very beginning? Suffice it to say that the most credible clinical position for a ther-

apist is to stay out of the patient's life after treatment ends. The patient should be allowed to go forward with his or her life, unencumbered by the therapist and the inevitable psychological baggage carried over from treatment.

Anonymity In the vignette, the relative anonymity of the therapist is not maintained. The patient is burdened by the problems of the therapist, wasting valuable treatment time that the patient needs for her own care.

Therapist self-disclosure is also a complex topic.³⁵ Self-disclosures that demonstrate the therapist's struggle with the problems of being human can be very supportive to some patients.³⁶ Patient and therapist shared regression is one of the obvious dangers of therapist self-disclosure. Although some therapists have found that sharing a personal experience may prove helpful to a patient, the self-disclosure of *current* conflicts and crises in the therapist's life may create a role reversion in the patient who then attempts to rescue the therapist. Even if role reversion does not occur, therapist self-disclosures in themselves may unnecessarily emotionally burden the patient. Details of the therapist's personal life, particularly sexual fantasies and dreams should not be shared with patients.³⁷ Therapist self-disclosures appear to be highly correlated with the development of therapist-patient sex.^{38, 39}

On the other hand, clinically appropriate self-disclosure may be necessary if the therapist is suffering from an illness that might negatively impact upon the treatment or may cause the therapist to

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be absent from therapy for a long period of time.

The practitioner's position of relative anonymity does not require that the therapist be a blank screen. The therapeutic relationship between therapist and patient is basically interactive.¹¹ For example, the therapist's overt and covert reactions to the patient can be therapeutically valuable in pointing out to the patient the repetitive nature of the patient-therapist interaction as it manifests itself in other important relationships.

Fees A fee should be established between the therapist and the patient that is mutually acceptable. Fees will change over time according to general economic exigencies and the personal circumstances of patients. Diminishing or discontinuing fees, however, must not be linked to boundary violations as a *quid pro quo* for therapist exploitation of the patient. The payment of the therapist's fee should be by money only. Nonmonetary forms of payment should not be accepted.⁴⁰

As demonstrated in the vignette, therapists who become sexually involved with patients frequently discontinue billing. Although this practice may have a number of meanings, the exploiting therapist often does so in the erroneous belief that not billing the patient terminates the treatment relationship and the possibility of being sued. The establishment and continuance of the doctor-patient relationship is not dependent on the payment of a fee.⁴¹

Treatment Setting As Langs⁵ points out, a consistent single, relatively neutral professional treatment setting provides a

set of physical constants that endeavor to maintain "a maximal degree of consistency, certainty, and stability" for the treatment experience to unfold. In the vignette, the psychiatrist meets the patient in a park and bar in addition to his office. Such practices tend to undercut the professional stance of the therapist and trivialize the treatment setting. Since many patients have suffered from inconstancy and intrusiveness in their relationships and physical environments, maintaining privacy, stability, constancy, and professionalism of the treatment situation is of critical psychological importance.

Behavior therapists, however, do accompany phobic patients into threatening environments and situations as an appropriate part of their treatment regimen. Therapists with religious orientations may accompany patients to their house of worship. Under exceptional circumstances or in an emergency, the therapist may need to make a house call. Thus, an absolute prohibition cannot be issued against meeting patients outside the office because of clinical exigencies that arise and the existence of reasonable variations in treatment approaches.

Psychotherapy cannot be conducted effectively over a telephone. Generally, the telephone is best should be used in making or breaking appointments or for emergencies. The patient should come to the therapist's office for treatment. The telephone or other technological devices (e.g., answering machines, beepers) should not be allowed to create barriers between the therapist and the patient.⁴²

On the other hand, therapists who

treat patients suffering from Multiple Personality Disorder often have to deal with alters over the phone. Sometimes, therapy may be temporarily conducted over the phone when patients cannot come to the office for reasons of work, travel, or physical illness. Medication adjustments between sessions may require use of the phone. Telephone interviews may be necessary in emergencies. If nonemergency telephone interviews are to be scheduled, they should be well structured, prearranged, time-limited therapeutic engagements, and paid for at the regular rates.⁴³

Time Defined time and length of sessions also add stability to the treatment relationship. Generally, in sexual misconduct cases, sessions progressively lose time definition both in scheduling and length. Therapists must always question their rationale for lengthening or shortening sessions. Longer sessions may cause certain patients to feel special and, thus, more vulnerable to exploitation. In the vignette, sessions went on for as long as three hours as boundary violations intensified.

On the other hand, the length of some sessions may need to be responsive to the exigent clinical needs of the patient. Patients in crisis may need additional time during a session. Patients with Multiple Personality Disorder (MPD) often require flexibility in the length of sessions. Putnam⁴⁴ recommends that MPD patients be seen for one and a half hour sessions. Prolonged sessions may be needed as various alters emerge.^{41, 45} Patients with MPD, however, can exert inordinate pressure on the therapist to

abandon conventional treatment boundaries.

Money—The Root of Many Boundary Violations

Boundary violations involving money and insurance matters are quite common.⁴⁶ Therapists should explain their fee policies at the beginning of treatment. Therapists are free to bill their services at rates established in a verbal or, sometimes, written agreement with their patients.

Billing for missed appointments may be appropriate if the patient is advised of this practice at the beginning of the treatment relationship. *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*⁴⁷ provides ethical guidelines concerning billing for missed appointments. These guidelines, however, state that one must treat the patient "always with the utmost consideration for the patient and his/her circumstances" (Section 2, Annotation 6). If the therapist charges for phone conversations, for preparing reports or lengthy insurance forms, the patient should be informed of this policy in advance. The American Medical Association's *Current Opinions of the Judicial Council* (Section 104, 6.06)⁴⁸ states that "the attending physician should complete without charge the appropriate 'simplified' insurance claim forms as part of his service to the patient to enable the patient to receive his benefits. A charge for more complex forms may be made in conformity with local customs."

Irregularities that occur with insur-

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ance companies concerning patient billing may be only one aspect of other concurrent boundary violations in the treatment. The failure of the therapist to clarify billing procedures with third-party payers may raise the question of collusion with the patient against the carrier. Any hint of dishonesty in the therapist's dealings with third parties will disrupt the therapist's position of neutrality and introduce mistrust into the therapist-patient relationship. For example, charges for missed appointments should not be represented as treatment sessions to third-party payers since it can be interpreted as misrepresentation. Moreover, the therapist may be sued for fraudulent claims by third-party payers for billing irregularities that appear to be deliberate.⁴⁹ Some therapists take the position that they do not want to act as the patient's conscience in billing matters. Hence, the therapist informs the patient that conflicts with the insurance carrier over payments for missed appointments will need to be clarified by the patient. The therapist makes clear on the billing statement the policy concerning charges for missed appointments. Other therapists indicate directly on the billing statement all missed appointments even if the patient objects. Then the patient's feelings are addressed as a treatment issue. In any case, not to clarify billing procedures with third-party payers may raise the question of collusion with a patient against a carrier.

When a patient has insurance but is unable to pay his or her own portion of the bill, "discounting" of the bill occurs if the therapist accepts no payment or a

smaller amount from the patient.⁵⁰ From the insurance company's perspective, the effect of this practice is to nullify their position that services are unlikely to be overly or inappropriately used when patients pay their part for the therapy. In most instances, insurance companies are responsible for a percentage of the psychiatrist's usual and customary fee. If the psychiatrist accepts the insurance reimbursement as payment in full when collection of the copayment from the patient is possible, the insurer is actually paying 100 percent of the fee. Insurance carriers consider this practice by therapists under contractual arrangement with the insurer to be fraudulent because the physician is pocketing their "overpayments."

"Inflating" bills refers to charging the insurance carrier a higher fee than the therapist is actually charging the patient. When this happens, the therapist pockets the difference or applies it to the patient's portion of the fee. Also, therapists must distinguish between three separate billing situations: illegal balance billing, charging one's insurance company profile fee to the insurer, and charging the patient a normal discounted fee—which is perfectly reasonable and is universally done.⁵¹ For example, it is illegal under most Blue Cross agreements in most states to bill a patient \$100, accept the \$60 Blue Cross payment and bill the patient for the balance of \$40. It is a perfectly acceptable approach for the psychiatrist to bill Blue Cross for his or her profile fee of \$60 but charge a patient who is paying out of pocket only \$40. The profile fee,

in this instance, is being discounted but not within the agreement with Blue Cross. When insurance benefits have been maximized or insurance is not part of the payment process, the therapist is free to directly negotiate fee arrangements with the patient.

Dishonesty over billing matters is a major boundary violation that is certain to have adverse consequences for the patient's treatment. Moreover, such practices may be exposed in court and the therapist's credibility can be severely undermined if the therapist becomes embroiled in a lawsuit with the patient at a later date.

Some patients undergoing treatment may find themselves unable to pay their bills. To do so, patients may offer to barter cars, jewelry, property, or other valuable items. The coin of the realm must literally always be money, the only acceptable medium of exchange when receiving payment from patients. Patients who desperately feel they need treatment, or who experience intense, positive transference feelings toward the therapist often are unable to render an arm's-length assessment of the monetary value of their possessions.

Similarly, therapists should tactfully refuse large gifts from patients and, if possible, the opportunity should be taken to investigate the meaning of the gift in the service of the treatment. This is not easily accomplished since some patients will feel devastated by having their gifts questioned. Some therapists graciously accept small gifts given by patients at the termination of therapy and leave it unanalyzed. A good rule to

follow is that full compensation for one's services is obtained from the fee received from the patient and the professional gratification derived from conducting competent therapy.

Therapists who become involved in business dealings with patients may later be accused of undue influence when purchasing valuable goods or property from the patient at below market value, or where the patient leaves the witting therapist a large amount of money in a will.⁵² Litigation is usually aimed at voiding the business contract or will. Although monetary damages against the therapist are not usually sought, the burden of proof is on the patient's estate to show that undue influence occurred.

Finally, the use of "insider information" obtained from the patient and used for the personal advantage of the therapist occurs with disturbing frequency. An example of self-serving occurred when a psychiatrist used a stock tip obtained from a bank executive's wife during the course of therapy to turn a large profit.⁵³ After the Securities and Exchange Commission learned from the patient of this transmission of "insider" information about a merger, it charged the psychiatrist with profiting illegally. Profits of \$26,933.74 were surrendered. The psychiatrist was fined \$150,000, sentenced to five years probation and 3,000 hours of community service.⁵⁴

Psychiatrists working in managed care settings frequently face major ethical concerns and potential serious double agent roles.⁵⁵ "Negative incentives" to cut costs at the expense of diminished quality of care is a major threat to the

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therapist's fiduciary commitment to patients.⁵⁶ A 1987 Hastings Center Report entitled, *New Mental Health Economics and the Impact on the Ethics of Psychiatric Practice: A Report of the APA/Hastings Ethics and New Economics*⁵⁷ recognizes the conflicting responsibilities that psychiatrists experience when simultaneously serving patients and institutions. The report underscores the psychiatrist's primary responsibility to the patient by stating that "the new reimbursement schemes share the financial risk with the provider and may incentivize the psychiatrist to take a clinical approach that is not entirely in the patient's best interest."

Double Agency and Dissonant Boundaries

Double agent roles frequently create the occasion for boundary violations in treatment. The problem of conflicting loyalties is a major concern to many psychiatrists.⁵⁸ It is also a common problem for other mental health professionals, lawyers, bankers, accountants, and a host of other professionals serving in fiduciary capacities. In the Hastings report⁵⁹ entitled, *In the Service of the State: The Psychiatrist as Double Agent*, the problem of double agency was studied from the perspective of the psychiatrist's conflicting loyalties when simultaneously serving the patient and an agency, institution, or society. For example, for the military psychiatrist, the professional duty owed to the soldier (patient) versus the loyalty to military's best interests poses a potential double agent role. Prison psychiatrists often are

confronted with the conflict of having to serve the interests of their prisoner patients, prison officials, and society. School psychiatrists must balance the interests of the student, the parents, and the school administration. Psychiatrists working in mental institutions must manage the conflicting duties to their patients with those of the institution and society. With the emergence of the *Tarasoff* duty to warn endangered third parties, the preservation of the patient's confidentiality conflicts with society's needs to be protected from harm. But as noted in the Hastings report, what has traditionally been called double agency is, in fact, multiple agency with conflicting responsibilities and confused loyalties due to of undefined purposes and contradictory goals.

Boundary violations, particularly those involving breaches of confidentiality, frequently occur when therapists must serve both the patient and a third party. Dual roles often skew the therapist's maintenance of appropriate treatment boundaries. Therapists should inform patients from the very beginning concerning any limitations placed on the patient's treatment, particularly limits on confidentiality due to dual responsibilities of the therapist. Suits for breach of confidentiality may arise from unauthorized disclosures.⁶⁰

Therapists may hold personal agendas that create a conflict of interest that can disturb a position of neutrality and create legal liability. For example, in *Roe v. Doe*,⁶¹ a psychiatrist was sued by a former patient for publishing a book that reported verbatim material from the

therapy including the patient's thoughts, feelings, and fantasies. In concluding that no valid patient consent for the disclosure existed, the court admonished the defendant stating, among other things, that

a physician who enters into an agreement with a patient to provide medical attention impliedly covenants to keep in confidence all disclosures made by the patient concerning the patient's physical and mental condition as well as matters discovered by the physician in the course of the examination or treatment . . . such is particularly and necessarily true of [the] psychiatric relationships.

Conclusion

Treatment boundaries set by the therapist fluctuate in response to the dynamic, psychological interaction between therapist and patient. As a consequence, boundary excursions inevitably occur in almost every therapy. The boundary sensitive therapist usually can reestablish treatment boundaries before the patient is psychologically harmed. Epstein and Simon⁶² have devised an Exploitation Index that provides therapists with early warning indicators of treatment boundary violations. A survey of 532 psychiatrists who were administered the Exploitation Index revealed that 43 percent found that one or more questions alerted them to boundary violations. Twenty-nine percent felt that the questionnaire stimulated them to make specific changes in future treatment practices.⁶³

Although "minor" boundary violations may initially appear innocuous, they may represent inchoate progression to eventual exploitation of the patient. If basic treatment boundaries are vio-

lated and the patient is harmed, therapists may be sued, charged with ethical violations, and lose their professional licenses.

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