REGULAR ARTICLE

Boundary Violation Ethics: Some Conceptual Clarifications

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The practices of both forensic psychiatry and clinical psychiatry appear to require and to use, in boundary-violation discourse, a special way of referring to the heightened attention to the ethics of interpersonal exchange. But this discourse and the judgments it expresses are each in need of closer scrutiny. A variety of factors make the determination of certain actions to be boundary violations unclear, including the range of alleged boundary-violating behavior, ambiguities in the fundamental metaphor of boundaries violated or transgressed, and confusion about the explanatory status of the value judgments boundary-violation language is used to express. In addition, disputes and disagreements regarding boundary-violation judgments require analysis—an analysis undertaken in this article through appeal to theories of professional role morality. Noted also is the significance of gender in boundary-violation ethics.

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Boundary-violation discourse may be said to be the *lingua franca* of psychiatric and other psychotherapeutic ethics today. Informal discussions about unacceptable behavior are rarely characterized in any but these terms. Although this language is perhaps overused, psychotherapeutic practice places more stringent restrictions on boundary transgressions than are found in other areas of medical practice.

Boundary-violation discourse is integral to forensic psychiatry, in which boundary-violating behavior is evaluated as impermissible or in other ways legally actionable. Here, behavior judged to be boundary violating leads to professional censure. It also gives rise to malpractice charges because of its damaging effects, such as suicide and regression to severe psychiatric illness. Because the courts and the examination rooms of professional boards are the setting where boundary-violation judgments are decided in specific cases, forensic psychiatrists are at the forefront in interpreting and shaping boundary-violation discourse. Moreover, the role conflict encountered by the therapist asked to serve as an expert witness is a kind of boundary transgression peculiar to the forensic setting.[1]

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Reference to boundary violations permits ethical evaluation of an important dimension of professional practice. But boundary-violation discourse often seems confused, ambiguous, and even contradictory. And boundary-violation judgments are marked by inconsistency, subjectivity, and disagreement. In an attempt to offer conceptual clarification of boundary-violation discourse, I begin with some basic methodological considerations: (1) difficulties defining or formulating criteria for boundary-violating behavior; (2) conceptual ambiguities in the fundamental metaphor of boundaries crossed and violated; and (3) misunderstandings of the explanatory status of the claim that certain actions constitute boundary violations. Two additional features of boundary-violation discourse require clarification. One is the status of the disputes and disagreements about boundary-violation judgments, analyzed herein by appeal to theories of professional role morality, (i.e., ethical constraints on conduct dictated by professional role). The last, the larger social meaning of much boundary-violating behavior, which allows us to see boundary-violation discourse as a form of social critique, is introduced through a brief discussion of boundary-violating behavior in relation to gender. The interwoven confusions addressed derive from two sources: the variety of factors involved in boundary-violation judgments and am-

biguities and insufficiencies in the language in which those judgments are expressed.

Although my discussion in this article focuses on preliminaries, its implications for forensic psychiatry should be apparent. Because boundary-violation discourse is so integral to forensic psychiatry, it is especially important that forensic psychiatrists and expert witnesses appreciate the complexity and assumptions that go into evaluating particular questionable actions as wrongful in this way.

Types of Boundary-Violating Behavior

One source of the confusion that attaches to boundary-violation discourse is the variety of behaviors denoted as boundary violating. These include physical contact between treater and patient (nonsexual touching, such as pats and hugs, as well as sexual intimacy); forms of self-disclosure on the part of the treater about personal matters, such as the insertion of aspects of the treater's personal life into the therapeutic discussion; breaches of confidentiality by the treater; what would otherwise be known as conflicts of interest (for instance when the treater initiates or permits a social or business relationship to exist at the same time as the therapeutic one, or when role reversal allows the patient to provide support or other gratification for the therapist); and finally, an assortment of improprieties associated with the therapeutic engagement (fee-setting, gift-giving, and appointment times and places, for example). In its broadest interpretation (one I consider misleadingly broad) the notion of boundary violation seems to encompass almost any form of exploitation and/or any behavior likely to diminish the therapeutic effectiveness of the engagement.

Added to the confusing breadth of attributions about boundary violations is another factor. Reference to boundaries occurs in two closely related contexts: "Internal," or psychic, boundaries, including so-called self-boundaries or ego boundaries, enter into much psychodynamic discourse about patients in therapy.[2] Those whose "external" boundaries are said to be violated by inappropriate actions on the part of their treaters also possess internal boundaries, evaluated as loose, rigid, weak, and strong. Opportunities for confusion and ambiguity thus are multiplied.

The Definition Problem

To the unwieldy breadth of this usage, which makes conceptualization difficult, is added another problem: Judgments of boundary violation seem to be extremely context sensitive. Gutheil and Gabbard[3] have argued that contextual framing is always required to tell us when, as they put it, a possibly innocuous boundary crossing becomes an unethical boundary violation. Context includes "the treater's professional ideology, the presence or nature of informed consent by the patient, the point in therapy in which behavior occurs, the respective cultures of the dyad, and such environmental factors as whether therapy occurs in a small town or in an urban center, and whether public transportation is available." The authors illustrate: "A therapist who gives a patient a ride home in a blizzard might be judged differently, depending on whether the therapy occurs in a prairie town or a major city with a subway, whether the patient feels coerced by the therapist to accept the ride, and whether the therapist also gives the patient rides when the weather is mild."[3] Context also explains how repeated boundary crossings can be transformed into boundary violations by their progressive impact or by their incremental increase.[4]

This context sensitivity precludes the possibility of codifying those boundary crossings that should be classified as boundary violations, according to these authors, thus making it impossible for us to provide a covering definition to demarcate the class of boundary-violating behavior.

Writing several years earlier, Brown[5] offered a similar critique of boundary-violation discourse to that offered by Gutheil and Gabbard,[3] noting the context-sensitive nature of these judgments, and arguing for the "futility of trying to identify (and then avoid) all behaviors which are potentially boundary-violating." Rather than a concrete model of boundary violations, Brown proposed conceptual criteria. Boundary violations occur in those instances in which (1) the client is "objectified," violating the Kantian prohibition on treating others as objects rather than as persons; (2) the therapist's impulses are gratified through the behavior; (3) the needs of the therapist are made paramount over those of the client; or (4) the client feels violated.

Brown's model goes some way toward avoiding the definitional problem raised in Gutheil's and Gabbard's[3] discussion. Not one of Brown's criteria is

unproblematic, however. Although capturing something important about the kinds of behavior usually judged to be boundary violating, the objectification of the client is itself an obscure criterion, the satisfaction of which would appear to be met by one or several of criteria (1) through (3). But criterion (2), the therapist's impulses are gratified through the behavior, also raises difficulties of interpretation. It may be true that boundary violations occur when behavior is engaged in solely to gratify the therapist's impulses. Yet, it seems implausible to designate as boundary-violating all behavior that gratifies the therapist's impulses. Behavior engaged in for some other therapeutic purpose may happen to gratify those impulses as well. (Indeed, without some satisfactions remaining to treaters, it seems doubtful any would stay in the field.) Brown's criterion (3), the needs of the therapist are made paramount over those of the client, does seem to capture some subset of the behavior widely judged to be boundary violating, but not all boundary-violating behavior fits this criterion. Boundaries may be violated in a misplaced effort to help, or through inappropriate sympathy, for example, and it would appear overly cynical to judge all such behavior as placing the needs of the therapist over those of the client. Brown's criterion (4), the patient feels violated, is also unsatisfactory. Paranoid or oversensitive clients are likely to feel violated in the absence of any actual violation. The treater may have an ethical imperative to uncover and discuss those feelings of violation, but she would be unlikely to be judged culpably responsible for them.

Other discussions of boundary violations rely heavily on two additional conceptual features not named by Brown: that the behavior in question is (or is potentially) exploitative and/or that it is detrimental or at least not conducive to therapeutic success.[6] A lack of understanding or empathy on the part of the treater may jeopardize therapeutic success without violating any conceivable boundaries, and an analysis into exploitative and potentially exploitative behavior also yields less than a satisfactory definition of boundary-violating behavior. On any assessment, the range of exploitative behavior seems to exceed the range of boundary-violating behavior. (Although wrong and exploitative, a treater's overcharging the patient or providing unnecessary or inadequate care, for example, would not generally be regarded as violating boundaries, although this is certainly unethical behavior of some kind.)

Confirming Gutheil's and Gabbard's[3] claims, then, a clear conceptual definition of boundary violations appears elusive. Nonetheless, this effort at definition is premature. Preliminary clarifications of the primary conceptual features of this discourse are called for, especially the metaphor—if metaphor it is—sustaining this discourse of boundaries and boundary violations.

What Is Bounded?

Touching, sexual and otherwise, crosses bodily boundaries. Sometimes, therefore, the subject of these claims—that which is bounded—appears to be the body. Breaching a patient's confidence, on the other hand, crosses nonconcrete boundaries. The subject here appears to be the psyche, person, or self of the patient—or her secrets. In other behavior labeled boundary violating such as inappropriate self-disclosure by the treater, or the example noted earlier of giving the patient a ride, it seems clearest to say that the dyad, the relationship between treater and patient, is the subject. (This echoes Gabbard's[7] remark that boundary violations concern the "edge or limit of appropriate behavior by the psychiatrist in the clinical setting.") In the literature on boundary violations, as well as in less formal discussions, each kind of subject (body, self or psyche, relationship) is implied, often in the same discussion, and no consistent or defined usage reveals itself.

In relation to boundaries, the subjects of self and psyche are better avoided. They are the subjects in that parallel internal boundary discourse that, because it at least seeks to be descriptive rather than evaluative and about the patient rather than the dyad, is not to be confused with the discourse of boundary violations under analysis herein. For clarity and economy, it can be stipulated that the therapeutic relationship is that which is bounded. This allows us to honor the extension of boundary talk to include cases such as treater self-disclosure and giving the patient a ride, and yet also captures more concrete violations, such as sexual and nonsexual bodily contact.

The claim that the therapeutic relationship, or what is sometimes identified as the therapeutic "frame," is the possessor of boundaries is found in some of the literature on boundary violations.[8,9] But what does such a claim mean? At risk of atomizing what is better seen in relational terms, I suggest it means that the relationship requires roles for each

participant. A role can be defined as a circumscribed (bounded) and rule-dictated way of behaving in a circumscribed context, when presupposed are (1) that persons adopt different roles with different social contexts, and (2) that there may be role incompatibilities that prevent a person's adopting more than one role at a time. Incompatibility between roles depends on how precisely the behavior prescribed for each is defined and how strongly each is differentiated. The precisely defined and differentiated roles of theater, where one may play Miranda or Prospero but not play Miranda and Prospero at the same time, illustrate obvious cases of role incompatibility. Once the differentiation of the two roles has been made clear, the "two hats" required of a therapist called to testify can also be seen to represent role incompatibility, as can other instances of dual-role activity, such as the therapist's engaging in a sexual or independent business relationship with the client while therapy is ongoing.[1,8,10]

Professional Role Morality

Boundary violations, in this analysis, are role violations. An account of boundary-violating action in terms of role violation offers little substantive progress alone. But it has positioned us to explore an important link—that between boundary violations and what moral philosophers have called professional role morality. (Professional role morality refers to the set of moral and ethical imperatives derived from professional conduct, status, or role.) This link enables us to sort and stack the several moral principles and theories informing boundary-violation restrictions and to better understand the special importance of boundaries for psychiatric practice. It is also useful as we approach the question of disagreement over boundary violations.

The role morality sometimes attributed to doctors, lawyers, and government servants in the practice of their professional duties introduces a kind of moral double standard, in that it prescribes different conduct for professionals than for other people. One version of this system is known as strong role morality.[11] Strong role morality asserts that what is morally permissible or even morally required by a professional role is not necessarily required and is sometimes not even permitted according to that common or broad-based morality[12] applicable to the rest of the community. Even when some action conflicts with the values and ends of broad-based morality, such as the patient's usefulness to society, (role) morality for the doctor or healer is dictated by the goal of maintaining the patient's health.[11–13]

Not all role morality is so strong, however. A profession's role morality may also require more, not less, stringent obligations than those dictated by broad-based morality. Weak role morality, which is widely accepted as characteristic of the professions, is often used as a marker of professional status.[11–14] Weak role morality never overrides the dictates of broad-based morality, however; it just adds to them. Strong role morality has often been challenged. Some refuse to accept that any professional roles could contravene the dictates of broad-based morality, and certainly the dangers surrounding the "just doing my (professional) duty" defense have been amply exposed.[15] But weak role morality is not vulnerable to the same criticisms.

Some of the expectations and limitations of roles denoting so-called boundary violations apply across all professional relationships. But there are also role expectations and limitations that are developed within and specific to the particular professional practice involved. The relationship between lawyer and client imposes constraints different from those in the relationship between doctor and patient, for example. While keeping in mind the constraints imposed by any professional relationship, we must identify and acknowledge those attaching only to relationships in medicine. Psychiatric relationships bring additional constraints, with more precise and narrowly drawn role expectations than govern relationships in the other fields of medicine. What is morally permissible in the relationship between internist and patient may be a boundary violation in the relationship between psychiatrist and patient, for example.

Recognizing this nesting of moral obligations, we can see that the relationship between psychiatrist and patient is constrained in three different ways: First, it must comply with general standards of professional ethics (by avoiding noncontractual exploitation of the patient and conflicts of interest, for example). Second, it must uphold the particular set of values guiding all medical practice, in which the patient's health is paramount and such principles of biomedical ethics as autonomy, benevolence, and nonmaleficence are adhered to.[16] Finally, there must be role constraints distinctive to psychiatric practice.

At least some of the psychiatrist's special constraints pertain to the means of achieving or maintaining, not merely physical, but also mental health. In psychiatry as traditionally construed, the therapeutic relationship or "alliance" means that the healing relationship is regarded either as the primary medium through which healing takes place, or at least as a *sine qua non*, without which healing could not take place.

It is because so much emphasis is placed on the use of the relationship within psychiatry that the role constraints particular to psychiatrists focus on the niceties of maintaining the boundaries of the therapeutic relationship. This point has been noted by Gabbard[7] in an illuminating discussion of the therapeutic rationale for limiting boundaries. Boundaries, he explains, are the

> . . .structural characteristics of the relationship that allow the therapist to interact with warmth, empathy, and spontaneity within certain conditions that create a climate of safety. . . the external boundaries of the treatment are established so that the psychological boundaries between patient and therapist can be crossed through a number of means that are common to psychotherapeutic experience. . . [including] identification, empathy, projection, introjection, and projective identification.

Summing up, then, the psychiatrist's ethical concerns are several: those imposed by his or her role as a professional, those by his or her role as a doctor, and those by his or her role in a practice in which the professional goal and good is mental health and the particular professional instrument is (often) the therapeutic relationship. Rather than imposing conflicting ethical duties, the three levels of weak role morality constraints impose a nested set of demands, all incumbent on the psychiatrist.

Explanatory Status

The judgment that "X is a boundary violation" is frequently introduced as an explanation of professionally and ethically unacceptable conduct. But, taken alone, this phrase promises more than it can deliver. Further grounding is required. The force of the judgment depends on implicit assumptions—observational, theoretical, and ethical assumptions—that are often the source of bias, disagreement, and conflicting opinion. Rather than "action X is wrong because it is a boundary violation" we should recognize that it is because it is wrong that X is (regarded as) a boundary violation and should be able to sort out why it is regarded as wrong.

Boundary-violation language requires allegiance to additional assumptions of several kinds, and these can be identified and sorted. Observational assumptions underlying these judgments are often causal hypotheses predicting the consequences of certain conduct, as we have seen (the belief that some particular action would likely diminish or enhance therapeutic effectiveness, for example). Such assumptions, in turn, rest on further, often theoretical, assumptions.

The theoretical assumptions implicit in boundary-violation discourse are of at least two kinds: psychological and moral. The respective cases of (1) post-termination sex between client and treater, familiar from the forensic setting, and (2) the treater's self-disclosure, familiar from the clinical setting, illustrate each of these kinds of assumption. Adherence to psychodynamic theoretical tenets may preclude any post-termination sex on the grounds that such activity forever represents a proto-incestuous union. Without adherence to such theoretical tenets, in contrast, no such theoretically grounded objection to post-termination sex would be maintained (although nontheoretical objections may remain, such as concern that the sex would jeopardize any later resumption of therapy).

Therapist self-disclosure is often regarded as boundary violating.[17] Within feminist therapy, in contrast, in which the relationship is construed as importantly and self consciously egalitarian, reducing what have been called "artificial and unnecessary barriers to equality"[5] through therapist self-disclosure is an essential part of the engagement, not a boundary violation. The feminist therapist's emphasis on equality reflects underlying values. Whether therapist self-disclosure is judged to be boundary violating depends, at least in part, on what moral theoretical tenets are presupposed.

More generally, then, theoretical presuppositions, psychological in the first case and moral in the second, ground and justify the claim that post-termination sex and self-disclosure, respectively, are or are not boundary violations.

Informal discussion with clinicians readily elicits the range of moral theoretical frameworks, models, and assumptions that underlie boundary-violation discourse. Six of the most common of these will be described. These alternative frameworks will perhaps only rarely yield substantively different judgments about whether a given action

is to be regarded as a boundary violation. Nonetheless, they represent significantly differing moral theoretical standpoints and differing forms of moral reasoning. *Kantianism*: Brown's[5] attempt to define boundary violations appeals to the Kantian ideal of respecting personhood, which precludes treating others as objects. *Principles of biomedical ethics*: Judgments that a particular action constitutes a boundary violation are sometimes grounded by appeal to one or several of the other traditional principles of biomedical ethics, such as beneficence or autonomy. Thus, for example, boundary violations are regarded as wrong because they detract from the patient's autonomy. *Utilitarianism*: These judgments are grounded in the framework we associate with utilitarian ethics, in which boundary crossings that increase suffering or disutility count as boundary violations. *Contractualist model*: Some judgments of boundary violation reflect allegiance to the contractualist model of doctor-patient relationships. In such a model, boundary transgressions are wrong because they break the compact, formal or implicit, between therapist and patient. *Hippocratic Oath*: The principle of nonmaleficence *primum non nocere,* often associated with the Oath, sometimes underlies boundary-violation judgments. Harm to the patient must be avoided, and boundary-violating actions are judged wrong because they are likely to cause harm. The principle also underlies the Oath's explicit injunction concerning confidentiality. Disclosing confidences is regarded as a boundary violation because of that injunction. *Fiduciary relationship*: Another underlying moral framework found in some of the literature on boundary violations introduces the value of trust and designates the therapeutic relationship as a fiduciary one involving special trust.[10,18] Boundary violations reflect perceived breaches of this special trust.

To sum up, the contextual features influencing boundary-violation judgments include a range of usually tacit assumptions—some observational, others theoretical—that can make good the force of any given boundary-violation prohibition or judgment. That prohibition or judgment is only as strong as, and is determined by, the force of these assumptions. "X is a boundary violation" is an empty assertion, requiring for its completion some context, including further presuppositions, tenets, or assumptions.

Disagreements About What Violates Boundaries

Few, if any, doubt that dual relationships,[9] such as engaging in sexual relations or forming a business partnership with a patient while therapy is ongoing, constitute wrongful professional conduct.[19] But away from these obviously egregious cases, opinion is not settled, as variations in the codes of professional ethics in the case of post-therapy sex have made abundantly clear.

Many within psychiatry are skeptical about the possibility of making progress or resolving ethical disagreements in these strongly contested cases. Such impasses are attributed to stubbornly subjective moral oppositions about which nothing further and nothing useful can be said. (Philosophers speak of irresolvable, unreasoned, "gut-level," subjective responses and attitudes such as these as "moral intuitions.")

But two aspects of the preceding discussion should serve to stem this skepticism about reaching agreement in these matters. The additional assumptions undergirding boundary-violation judgments is one; the distinction between different kinds of nested role obligation is the other.

Underlying Assumptions

That some intuitive moral differences may be present when there is disagreement about boundary violations is undeniable. But because judgments of boundary violations seem to rest on additional, implicit assumptions, it is more likely disagreement about these underlying assumptions than intuitive and immediate moral disagreement that explains differences of judgment regarding particular alleged boundary violations. Using surveys, Kardener *et al.*,[20] in a well-known study, established that 86 percent of psychodynamically oriented therapists and only 61 percent of behavioral therapists believe that erotic contact is never of benefit to the patient—a finding that illustrates the way that aspect of context, which includes theoretical orientation, influences such judgments. We saw earlier what is probably reflected in these differences. More psychodynamically oriented therapists would preclude erotic contact because of their theoretical beliefs about the nature of the transference. Behavior therapists could find fewer theoretical grounds for such an objection.

As Kardener *et al.*[20] illustrate, assumptions from psychological theory account for much disagreement about boundary violations. Such assumptions are themselves elaborate, multilayered observational and theoretical presuppositions not easily open to experimental verification. Although they also may constitute irresolvable sources of difference, they are not to be confused with intuitive moral disagreements.

Different Role Obligations

Some apparently irreducible disagreements may reflect a failure to acknowledge the complexity of the psychiatrist's several different kinds of role obligation, as the following (hypothetical) case illustrates. A new patient grants permission to the treater to contact her spouse. Months later, when the therapeutic relationship is ongoing and without again raising her intention with the patient, the treater telephones the spouse. The patient feels violated. Note that because the patient feels violated, this is deemed a boundary violation under Brown's[5] criteria. Under a contractual informed-consent model, however, no rule appears to have been breached, in that the explicit terms of engagement permitted this action on the part of the treater.

This may be less an irresolvable disagreement or a case of competing moral frameworks than a misunderstanding of role, nonetheless. The contractual model applies in this transaction just as it would in any—whether psychiatric, medical, or nonmedical—between professional expert and fee-paying client. General professional role requirements would have allowed the treater to contact the spouse, as long as that explicit agreement had been established.

Granted, this case is complicated by the element of time, and a more enlightened and ethically sensitive approach understands informed consent to be an ongoing process subject to revision as therapy proceeds. Nonetheless, the basic legal notion of contract is time insensitive, or time spanning, and when issues of legal liability are concerned, the informed consent extends for the duration of the treatment.

But strictures specific to medicine and or psychiatry may well prohibit contacting the spouse later. If the action were deemed one likely to diminish trust in the therapist, when such trust was regarded as essential to the effectiveness of the therapeutic relationship, for example, then the moral role obligations of the treater render this boundary crossing a boundary violation.

The Gender Context

An additional aspect of boundary-violating behavior and boundary-violation discourse not raised thus far concerns the gender bias within the broader system where these boundary violations take place and the larger social meaning of much boundary-violating behavior. Other forms of bias are also found in therapeutic relationships, of course. But because of the frequency of sexual boundary issues in a professional setting where females are often treated by males, the gender context deserves special attention. Feminist bioethics has stressed the extent to which medicine, with its patriarchal practices, is a system that has harmful effects on women.[21] Because women's experiences within medicine echo their experiences in society, these two sets of experiences are mutually reinforcing.

Karasu[22] has pointed to several features of our broader societal structures that form an interlocking, reinforcing systemic harm within psychiatry: androcentric theory, training practices, and—most pernicious—the replication within the therapeutic relationship between male therapist and female patient of a position in which women typically find themselves in their lives in general. Even allowing for the greater numbers of women in therapy and of men as therapists, a significantly higher number of women than men are the victims of those boundary violations concerning sexual contact.[23–25] This personal harm and exploitation inflicted on women represents an extremely troubling aspect of psychiatric practice. But as Karasu[22] illustrates, this is harm that is systemic as well as personal. Since it sustains a broader, systemic social wrong, boundary-violating sexual behavior constitutes wrongful conduct greater than the sum of its particular, personally harmful occurrences. In drawing attention to that systemic social wrong, boundary-violation discourse plays an important part in social critique.

Conclusions

To the extent that psychiatry employs traditional psychotherapeutic methods, its particular focus on relationship means that boundary-violation ethics are more elaborate and more critical in psychiatry than in other medical fields. This discussion has explored several features of boundary-violation discourse: conceptual ambiguities and unclarities in its fundamental metaphor; difficulties defining or for-

mulating criteria for boundary-violating behavior; and the explanatory status of the judgment that some action constitutes a boundary violation. In addition, its link to professional role morality and its part in social critique were examined. Four points were particularly emphasized. First, claims about boundary violations do not stand alone; they depend on context. Thus, a boundary-violation ethic would be incomplete without the explicit acknowledgment of aspects of context, including the observational and theoretical assumptions on which, as a set of prohibitions, it rests. Second, by recognizing boundary-violation ethics as a form of weak role morality, it is possible to sort the moral theoretical tenets underlying the role constraints involved, some deriving from professional ethics that are most generally understood, some from biomedical ethics, and some particular to psychiatry. Third, boundary-violating behavior that is sexually exploitative often constitutes part of a systemic social wrong, as well as a personal violation. Finally, some disagreements over boundary violations stem from irreducible, intuitive differences of moral conviction. But many stem from other sources, including two in particular: a failure to recognize the different role constraints involved and differences in the theoretical beliefs underwriting boundary-violation judgments.

A special language is needed to acknowledge and codify the heightened attention to the ethical constraints on interpersonal exchange characteristic of clinical and forensic practice. But the confusions in boundary-violation judgments must be clarified, and the terms of boundary-violation discourse refined, before fully professional determinations about these very complicated interactions can be achieved.

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References

1. Strasburger L, Gutheil T, Brodsky A: On wearing two hats: role conflict in serving as both psychotherapist and expert witness. Am J Psychiatry 154:448–56, 1997
2. Radden J: Relational individualism and feminist therapy. Hypatia 11:72–96, 1996
3. Gutheil T, Gabbard G: Misuses and misunderstandings of boundary theory in clinical and regulatory settings. Am J Psychiatry 155:409–14, 1998
4. Simon RI: Therapist-patient sex: from boundary violations to sexual misconduct. Psychiatr Clin North Am 22:31–47, 1999
5. Brown L: Boundaries in feminist therapy: a conceptual formulation, in Bringing Ethics Alive: Feminist Ethics in Psychotherapy Practice. Edited by Gartrell N. New York: Harrington Park Press, 1994, pp 29–38
6. Garfinkel P, Dorian B, Sadavoy J, Bagby RM: Boundary violations and departments of psychiatry. Can J Psychiatry 51:357–75, 1997
7. Gabbard G: Boundary violations, in Psychiatric Ethics. Edited by Bloch S, Chodoff P, Green S. Oxford: Oxford University Press, 1999, pp 141–60
8. Gold S, Cherry E: The therapeutic frame: on the need for flexibility. J Contemp Psychother 27:147–55, 1997
9. Plaut SM: Boundary violations in professional-client relationships: overview and guidelines of prevention. Sexual Marital Ther 12:77–94, 1997
10. Welfel ER: Ethics in Counseling, and Psychotherapy: Standards, Research, and Emerging Issues. London: Brooks/Cole Publishing Co., 1998
11. Luban D: Lawyers and Justice: An Ethical Study. Princeton: Princeton University Press, 1988
12. Oakley J, Cocking D: Virtue Ethics, and Professional Roles. Cambridge, UK: Cambridge University Press, in press
13. Pellegrino E, Thomasma D: The Virtues of Medical Practice. New York: Oxford University Press, 1993
14. Churchill L: Reviving a distinctive medical ethics. Hastings Center Report 19:815–7, 1989
15. McIntyre A: Social structures and their threats to moral agency. Philosophy 74:311–29, 1999
16. Beauchamp T, Childress J: Principles of Biomedical Ethics (ed 4). New York: Oxford University Press, 1994
17. Barnett J: Should psychotherapists self disclose? Clinical and ethical considerations, in Innovations in Clinical Practice: A Source Book (vol. 16). Edited by VandeCreek L, Knapp S, Jackson T. Sarasota, FL: Professional Resource Press, 1998, pp 419–28
18. Jorgenson L, Hirsch A, Wahl K: Fiduciary duty and boundaries: acting in the client's best interests. Behav Sci Law 15:49–62, 1997
19. Appelbaum P, Jorgenson L: Psychiatrist-patient sexual contact after termination of treatment: an analysis and a proposal. Am J Psychiatry 148:1466–73, 1991
20. Kardener S, Fuller M, Mensh IN. A survey of physicians' attitudes and practices regarding erotic and non-erotic contact with patients. Am J Psychiatry 130:1077–81, 1973
21. Sherwin S: Patient No Longer. Philadelphia: Temple University Press, 1992
22. Karasu T: Ethical aspects of psychotherapy, in Psychiatric Ethics. Edited by Bloch S, Chodoff P. Oxford: Oxford University Press, 1991
23. Gabbard G: Sexual Exploitation in Professional Relationships. Washington, DC: American Psychiatric Press, 1989
24. Gartrell N: Bringing Ethics Alive: Feminist Ethics in Psychotherapy Practice. New York: Harrington Park Press, 1994
25. Barnes F: Complaints, and Grievances in Psychotherapy: A Handbook of Ethical Practice. New York: Routledge, 1998