

Boundaries, Blackmail, and Double Binds: A Pattern Observed in Malpractice Consultation

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A scenario common to several boundary violation/sexual misconduct cases is reviewed and discussed. Common features include an articulate patient whose high functionality concealed more primitive dynamics that arose in the therapy; boundary problems, often on an "attempted rescue" basis; and eventual litigation in some form. The patient's high functioning appeared to cause the therapists to underestimate the severity of the patients' disturbances. Drawing on forensic experience, the author analyses the cases and suggests risk management approaches.

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In malpractice prevention and risk management consultation, boundary questions are a very common concern among consultees. Such questions account for a considerable portion of legal and ethics-related difficulties for clinicians. The subject has been extensively discussed in the professional literature (see, for example, Refs. 1–10).

Over time, a particular pattern has emerged that seems to pose repeated problems and create familiar pitfalls for the therapists involved. This review lays out the pattern and indicates the underlying difficulties and possible risk management solutions to the dilemmas involved. The data for the cases discussed in this review were gathered from litigation in civil suits, complaints to local boards of registration, and complaints to ethics committees of relevant professional organizations.

The author's vantage point was as defense expert witness in the cases; the author acknowledges a potential source of bias arising from this position. Because the patients were in treatment, many of their dynamics were available. The therapists were only sometimes examined; hence, their dynamics as discussed in the article are more inferred and speculative. However, even the inferences are indirectly sup-

ported by the fact that many of the difficulties are familiar from the author's extensive experience in similar cases as expert for plaintiff or defense.

A caveat is in order: no one truly knows what actually happened in office encounters with only two people present, and the data emerged from contentious legal proceedings. Thus, any instructive value this review may offer is in the subjective dilemmas described by the therapists about whom complaints were lodged. Risk management principles may still be derived, despite this inherent uncertainty as to the truth of descriptions of the events.

All examples are from public hearings (trials, board hearings). In addition, all identifying data have been removed.

Case Examples

Example 1

A highly intelligent and psychologically sophisticated social worker was in an analytically oriented psychotherapy. After each session, she would drive away a short distance, park, and then write down her own version of "process notes" about what had transpired in the session as she saw it. As her transference to the therapist intensified, she researched his background without discussing it in therapy and became intensely aroused when she discovered a sexualized nickname the therapist had been called many years earlier during residency. This discovery led her to

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(mis)interpret some of the therapist's exploratory questions as sexual advances, and she brought a complaint against the therapist.

Example 2

A doctor in therapy was encouraged to keep a journal of her progress, in part because throughout the treatment she paid attention to, and seemed to remember, only what the therapist said, essentially ignoring her own contribution to the dyadic dialogue. The patient later thought of writing a book on the therapy, based on those notes. The therapist did not discourage her. The therapist was invited to write the introduction to the book, but although he considered it, he never wrote it. In a later ethics complaint, the patient complained of this decision to consider it as "fostering an idealization of the therapist." The case evidence suggested that this idealization was spontaneous and could not have been prevented. The patient also presented the therapist's exploration of her sexual fantasies as "mutual participation in sexual fantasies which went well beyond transference issues." This highly subjective interpretation was regrettably taken as simple fact by the ethics committee.

Example 3

An intelligent and articulate professional with borderline personality disorder frequently called the therapist with serious threats of suicide, which she would sometimes—but not always—retract. After responding appropriately multiple times without hospitalizing the patient, the therapist received a call that the patient was precipitously stopping treatment during a period of intense stress. The therapist, becoming concerned about suicidality, hospitalized the patient involuntarily over a weekend. The patient brought an ethics complaint against the clinician before the latter's professional organization, based on the question: "How could the doctor have been so foolish and incompetent as to imagine I was ever truly suicidal?" In an attempt to mediate her own case, the patient generated a 22-page, single-spaced "model apology" that the treater was invited to sign. This document, composed by the patient as though by the therapist's hand, consisted almost entirely of abject, self-excoriating "pleas for forgiveness" by the therapist, coupled with extended riffs on how the therapist had violated all possible standards of care. Needless to say, the therapist did not sign it.

Example 4

An intelligent and articulate patient repeatedly complained of intense difficulty with separation from the therapist and failures of object constancy between sessions, such that therapy might not be able to continue. Among an extensive series of boundary transgressions to deal with this problem and keep the therapy going, the therapist gave the patient a shirt he had worn so that she could keep it on her pillow at night and fall asleep smelling the therapist. This action became a part of the later complaint, which the patient brought when the therapist had retracted a boundary crossing (a promise to come to the patient's home in the evenings after therapy was over) under advice from risk management, and the patient stated: "I didn't know who he was any more."

Example 5

A therapist working in another country was treating a highly functional but difficult, demanding, and intrusive patient with borderline personality disorder. The patient attempted several times to intrude on the therapist's outside life. During one session, the patient suddenly loosened her clothing and began to masturbate in the office. The therapist, feeling paralyzed and anxious, immediately left the office and consulted the board regulations. He discovered that if he attempted to obtain any consultation, even private and personal consultation on the case, the consultant would be obliged, by that country's stringent policies, to report him to the board on the basis that he "participated" in (i.e., by observing) a sexualized activity in the office (this perception was confirmed by a local attorney). The therapist felt blackmailed and unable to take any useful action when the patient repeated this behavior in a subsequent session. Eventually the case became the focus of a complaint.

We can imagine that, had the therapist taken the risk of presenting the case to a colleague, his position might well have been stronger in the subsequent investigation. Instead, he continued to see the patient alone in the office while foreseeing that the behavior would continue.

Example 6

In a similar situation, a female counselor was working with an extremely difficult female patient with borderline personality disorder and possible dissociative identity disorder who was also a severe self-

mutilator. The patient had had long experience in various therapies. She had several extreme sensitivities (based on her abuse history) that included an intense need for privacy. This encompassed not wanting certain things to be written down in the notes, resisting supervision or consultation, and threatening self-mutilation when thwarted. The counselor attempted to navigate this minefield of traumatic associations by crossing multiple boundaries, in the form of many phone calls outside business hours, home visits, and exchange of very personal cards and letters. On one occasion the patient took the counselor's hand and attempted to place it on her own breast. The counselor allegedly interrupted her attempt before contact. This act was later presented as, "She touched my breast." After much treatment for trauma-related bodily numbness the patient began for the first time to feel physical sensations in the office and began to masturbate. The counselor felt utterly trapped and held hostage in a double bind: to stay in the room would be to participate passively; to leave, get consultation, or have someone come in would be, she feared, to trigger severe self-mutilation, as had occurred before, when some aspect of past abuse (invading privacy) was symbolically "repeated." When, after reflection, the therapist refused a particular boundary crossing, the patient called the counselor's clinic and brought a complaint. When the clinic and counselor went into "complaint mode" and began to investigate the matter—including having someone sit in on the therapy—the patient protested that she had not brought any complaint; rather, one of her alters had, and she complained bitterly about the measures designed to protect her from the alleged misconduct. The patient later did file a complaint filled with allegations of sexual behavior, much of it implausible, by the therapist. In the subsequent board complaint, all the patient's allegedly requested responses in the form of boundary-crossings were presented as though they had been initiated by the therapist for the therapist's own needs. Although in her complaint the patient claimed that detailed and extensive perverse sexual overtures and actions had been initiated by the therapist, the board, apparently inflamed by these descriptions, seemed not even to consider that the described acts between two stably married, heterosexual women might at least be relatively implausible.

In the two cases involving masturbation in the office, it is likely that the appropriate response would

have been simply to tell the patient to stop doing that. In both instances, the countertransference-based paralysis of the treaters apparently prevented this simple approach.

Commonalities in the Cases

It may be useful to review some axioms about boundaries before the ensuing discussion. First, only the therapist has a professional code to violate, and only the therapist may be held responsible for failing to set or adhere to boundaries. That said, the patient's dynamics may be appropriately studied without "blaming the victim" or exonerating the deviant therapist.⁸ Second, all events in therapy have an interactive component. The material in this article is presented in that context.

In the case examples, the patient was often either a professional or a sophisticated person who was trained or experienced in psychology, psychiatry, or psychotherapy. Often they were extremely intelligent and articulate. In several of the cases, the patients were more articulate than the therapist and, consequently, more convincing in telling the story of their complaints. Patients with personality disorders, perhaps in particular those with borderline personality disorder, are distinguished from those with other forms of psychopathology by the possibility of successful, high functioning outside intense relationships; indeed, the decompensations in the cases were limited to the transference relationships.

The patients' high functioning concealed primitive dynamics that were largely missed by the therapists. The high functioning also allowed the patients, within litigation and outside the transference-bound relationship, to present their cases persuasively, despite the "craziness" of some of the content. Of course, the transference itself and its mismanagement may have brought out regressive trends not present in the patients' outside lives. An earlier communication¹ described how this functioning on two levels can confuse and mislead legal fact-finders about the validity of the patient's perceptions. This uncertainty was clearly present in the litigations of the case examples.

These patients shared many qualities of the "special patient,"¹⁰ for whom rules were often bent and exceptions made, in a form of VIP syndrome.⁹ Such dynamics are common when the patient is also a professional or someone regarded as nearly a colleague of the therapist. Those very dynamics may be

enhanced by regressive and idealizing countertransferences and milieu attitudes toward the patient. Though none of these cases allegedly involved actual sexual misconduct, these qualities in the patient may be seen as attractive to therapists, especially those in midlife crises.

The therapist's own narcissistic traits appeared in some of the cases to produce a mirroring fusion that might be described as: "I'm special, you're special." This self-gratifying mirroring may contribute to the therapist's being "sucked in" to an inappropriate relationship.

Another factor that appeared operative was "cessation trauma," a term describing the fact that any latent tensions or conflicts (that are avoided or suppressed during the relationship) emerge, sometimes forcefully, at the cessation of the relationship, when the patient feels abandoned or betrayed in some way.⁸ The cessation is also commonly accompanied by reversal of the splitting that was going on during the relationship: the "all good" therapist abruptly becomes "all bad."

The patients in this group tended to be extreme externalizers and projectors, laying the origin, source, or cause of the therapeutic events entirely at the treat-er's feet. Examples might be:

"I feel sexually aroused; therefore, you are being sexually seductive, and your interventions are intended solely for your gratification."

"You are exploring this sexual topic, not for my benefit but for yours."

"I feel pain; therefore, you are being sadistic."

For balance, we recognize that all projective identifications may occur in the context of a "grain of truth." The projection is aimed at aspects of the therapist that appear to the patient to be receptive. For example, some patients with personality disorders experience being particularly well understood as seductive.

These externalizations tended somehow not to be closely scrutinized by the fact-finders in the cases, perhaps because of the articulateness of the patients. In a related context, many of these patients combined externalization with being intensely obsessional, a trait they expressed by nit-picking the accuracy of details and by losing sight of the forest by focusing on individual trees taken out of context, as it were. These obsessional traits also led some of these patients to generate extremely lengthy and detailed affidavits, statements, or 30-page documents re-

questing experts to aid their cases; such preparations may have had a power proportional to their volume instead of their validity.

Another commonality is the way in which the patients apparently exerted significant pressure on the therapists in the form of emotional or actual blackmail, employing explicit or implicit threats of suicide, self-mutilation, impasse, failure of the therapy, exposure to sexual activity, or refusal to speak. The pressures appeared to be attempts to effect boundary transgressions in the service of the patients' needs. Of course, the therapist's task is to resist these pressures.

The patients appeared to press as well to bring out the therapist's creativity and originality in the therapy—often in the form of making exceptions to usual practices—to deal with specific dynamic issues or sensitivities. The creative or original interaction was then treated as deviance in the patient's subsequent complaint. Thus, in the final reversal, when legal or quasi-legal action was brought, the boundary event was treated as a harmful and distressing violation, and the patient's own role in it was ignored or minimized. This formulation in no way excused the therapist from the responsibility of setting boundaries in the first place.

The emotional "blackmail" in these scenarios appears to act in two directions as a double bind. The therapist who crosses the boundary is doing bad work. If the therapist does not cross the boundary, it reveals lack of skill or care and concern for the patient, and the patient may respond by self-mutilation or suicidality. Some of the therapists in the examples given appeared to the forensic consultant to be stymied by exactly this dilemma.

In all the cases described herein, the therapists were stretching the boundaries for both good and bad reasons. The "good reasons" included attempting to "individualize" the therapy to respond to the patient's unique needs or concerns. Some of these well-intentioned outreaches were aimed at meeting the patient's dependency or regression at its own level, so to speak, based on the belief that placing more adult expectations on the patient was inappropriate and ineffective. As is so often the case in the countertransference to personality-disordered patients, the therapists' conflicts about sadistic feelings appeared to play a part in the paralysis and difficulty in adhering to boundaries that occurred in these cases.

The “bad reasons” apparently included failing to hold the line because of rescue dynamics and wishes to be perceived as an idealized parent or partner. This apparently led to therapists’ participating in gratifying experiences that did not clearly aid the patients in mastering primitive strivings. Guilt about unconscious wishes for closeness or idealization appeared also to play a role in the feelings of paralysis noted earlier.

Some of the more bizarre claims noted herein would have been likely to fail in a formal civil litigation; however, the therapists could still be put through the emotional wringer of preliminary discovery and board or ethics hearings in some cases, with the attendant threats of loss of license or professional censure.

Finally, when the therapists attempted to stop or decrease the boundary crossings or violations, some of the patients reacted strongly to this perceived rejection and brought a claim.

Recommendations

What risk management advice can be extracted from the above patterns? We know that we are supposed to take good notes and to obtain consultation, but this does not seem to prevent determined patients from acting out their projective fantasies or credentialing bodies from believing them. The major point in this article, beyond the more standard advice reviewed in the following paragraphs, is that patients with high levels of functioning and/or experience with psychotherapy may conceal the primitiveness of those fantasies and enactments and mislead treaters accordingly. Moreover, the therapists described, while usually not acting in an exploitative fashion, clearly did make demonstrable errors in treatment that may have played a significant role in bringing out those very dynamics.

The first lesson is that even theoretically benign boundary crossings can be misconstrued or portrayed in a worse light in later litigation. Boundary crossings thus require circumspection, weighing of pros and cons, and obtaining consultation with a low threshold.

Second, clinicians must be willing to hold the line. The clinician is responsible for setting and maintaining the boundaries, even if the patient threatens self-harm or flight from therapy. Such a position can be extremely challenging to retain under pressure of the more primitively motivated patients’ intense de-

mands. Yet it is part of the therapist’s burden. Therapists should recall that one description of the tasks with patients with primitive tendencies is to resist reinforcing the primitive strivings and to foster and encourage the adult strivings.

Third, therapists must accept that good therapy may fail or be rejected by the patient because it is not gratifying enough. Therapists must accept that some patients will feel they are not getting what they want and will discontinue therapy.

Fourth, when the therapist feels or is being blackmailed, it is important to weigh the price. If adhering to proper responses results in the patient’s engaging in self-mutilation, the therapist must tolerate this possibility while holding the behavior up to scrutiny. No therapy can proceed if the only goal is preventing self-harm. Victims of blackmail are sometimes advised by police, “Don’t pay the first dollar” (Strasburger LH, personal communication, 2004). The analogy would be, do not make the first compromise of appropriate boundaries. In this context, therapists, when pressed to make exceptions to usual procedure that might constitute deviance or boundary compromises, must be free to say to patients, “Even though you may believe that would be helpful, I am just not comfortable doing it.”¹¹

Fifth, the importance of objective documentation—reporting on the exact sequence in which events unfold—cannot be overstressed; this documentation captures the decision-making that aids in refuting the claim that the therapist negligently failed to use clinical judgment. In the always problematic situation of a patient’s masturbating during therapy, the therapist who documents the decision to stay, leave, comment or not comment, or tell or not tell the patient to stop is making a clinical decision. The therapist who writes nothing may be seen as a gratified, passive voyeur. The failures of documentation may have played a significant role in impressing the fact-finders in the case examples.

Finally, consultation is so important to preserving the value of clinical work that resistance on either side should constitute a “deal-breaker.” This is perhaps especially relevant in Example 6. In general, a treater who refuses a patient’s authentic request for a consultation is failing in the task, and the patient should discontinue therapy. A patient who attempts to keep a treater from obtaining an appropriately anonymous consultation should be told that that is not acceptable. In Example 4, this failure may have

been a decisive point for the board. If the therapist obtains an anonymous consultation, the therapy may actually benefit more if the patient does not know about it. This curious observation stands in contrast to the usual notion of confidentiality as a “one-way valve”: what is learned outside therapy comes in, but what is learned within does not go out.

Though at times distressing and even painful, therapy for these challenging persons can be successful despite the intensity of their drives, externalizations, and distortions. Such success, however, may depend on the therapist’s resoluteness in remaining within the bounds of the therapeutic exploratory chair despite the various pressures that have been discussed herein.

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