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Prevention of Boundary Violations

The Role of Education, Self-Monitoring, and Consultation

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Prevention of professional boundary violations in psychotherapy is a matter of crucial importance for the mental health field. Patients are damaged by boundary violations. Psychotherapists' careers are ended. Families of therapists and patients alike are devastated. And last but not least, the reputation of mental health professionals, and psychotherapy in particular, is damaged in a way that takes a great deal of effort to repair. Cinematic and television depictions of psychotherapy cannot resist showing therapists as weak-willed individuals who cavalierly disregard professional ethics to gratify their own needs.[1]

Despite the clarion call to monitor boundaries that the mental health professions, the licensing boards, and the ethics committees have sent out to all clinicians, the professional violations that have caused so much distress for so many continue. Prevention is far more complicated than one might think. While there are, of course, a variety of measures that can be taken, none of them is foolproof. Psychotherapy requires a radical form of privacy that is essential for the development of trust in the therapeutic relationship. Patients must feel that they can pour their hearts out to their therapists without having to worry that there will be an adverse impact on any other sphere of their lives. Hence, the therapeutic frame (ie, 2 people talking intimately behind a closed door) ensures that the mental health professions will never be able to monitor what transpires between therapist and patient in anything approaching a fail-safe manner. Boundary violations will occur no matter how hard we try to prevent them. The best we can hope for is to reduce their frequency and severity.

Everyone agrees that a fundamental ethical premise of the psychotherapeutic setting is that the patient's needs must be placed before the therapist's needs. Unfortunately, this distinction can become elusive in many situations where the therapist develops desire for the patient. In such situations, the therapist begins to rationalize that certain unorthodox behaviors will ultimately be in the patient's best interest. If the patient was deprived of loving parents, the therapist may argue that he or she must become like a parent and love the patient better than the parents could. From this point of view, deciding to provide treatment for free, to visit the patient outside scheduled hours, and to provide hugs and other forms of physical contact to prove one's caring and affection for the patient can be justified as "re-parenting." Psycho- therapists, like all human beings, are masters of self-deception. We can all convince ourselves that what appears to be in our best interest to any outside observer is actually in the patient's best interest. In spite of these limitations, a number of preventive approaches may have a significant effect on the profession.

Education

Education occurs in a variety of settings. Didactic seminars in psychiatric residency, clinical psychology graduate schools, and social work pro- grams can teach fundamental ethics. Supervision is helpful in operationalizing these ethical principles into a form of technique. After psychotherapists are in practice, continuing education occurs in workshops, lectures, through supervision/mentoring, and study groups. Education of the public may also be useful in preventing boundary violations.

In didactic seminars, the reasons for professional boundaries must be made explicit to students in the mental health professions. Such concepts as transference, countertransference, the power differential in fiduciary relationships, and the notion that sex can be exploitative even when a patient says it is "consensual" must be part of every future psychotherapist's education. Boundaries and ethics cannot be taught as a list of rules. They must be embedded in the teaching of good clinical technique. Students must learn that they will always encounter feelings of various kinds in the treatment of patients, and that they must find ways of working with such feelings rather than disavowing them or acting them out.

Another aspect of education must be practical instruction in how one should manage a treatment impasse.[2] Educators must emphasize again and again that isolation is perhaps the greatest risk in the therapist's career. A culture of seeking consultation and supervision must be ingrained in trainees so that they do not attempt to be the "Lone Ranger" when confronted with difficult clinical situations. Students must be taught that there is nothing inherently noble in figuring out solutions to clinical problems on one's own. Trainees should learn the warning signs that signal a higher than usual potential for boundary violation. Much of this can be packaged in terms of the "slippery slope" concept.[3] Most egregious boundary violations are preceded by subtle breaks in the therapeutic frame that progress over time, such as extending the session or hugging the patient. Catching one's first missteps through a rigorous self-monitoring process can help avoid progressing down the slope.

Education of the public should be another goal of the mental health professions. In books and articles written for the lay public, we must stress that sexual relations between a patient and therapist are never acceptable, and that there are many nonsexual boundary violations that can be equally harmful, such as financial transactions with patients that are outside the payment of the fee for service. Some psychotherapists place written materials in their waiting rooms so that all patients are apprised of the professional boundaries inherent in ther- apy and can be alerted to behavior that seems at odds with community standards.

Education of psychotherapists will go only so far as a prophylactic measure, however. The truly unscrupulous individual with antisocial traits or severe narcissistic personality disorder with superego lacunae may be completely impervious to education. Such therapists may smugly believe that they know what is best and do not need to follow the guidelines of the profession. Even ethical and well-trained psychotherapists will encounter certain patients who, in some way, touch a nerve deep within them that results in a steady and gradual increase in rationalizing unethical behavior. Hence, the bottom line of all educational efforts must be to teach psychotherapists to make consultation a regular part of their practice. In this sense, therapists need not wait until they are in a difficult situation to avail themselves of a supervisory or consultation process as a safety net in their regularly scheduled activities.

Consultation

Intrinsic in the value of consultation is that therapists can never see themselves fully from their own internal perspective. A consultant has an outside point of view that is capable of observing behaviors and nonverbal communications that are missed by the therapist's own self-scrutiny. Countertransference blind spots may be more apparent to a consultant, especially one who has been involved over a period with a particular consultee, so that alterations in the therapist's usual way of working are more easily identified.

Sexual boundary violations have often been referred to as forms of professional incest. This model has heuristic value because incest involves 2 parties who have a secret relationship outside the conscious awareness of a third party. The introduction of a consultant into the therapeutic dyad shatters the forbidden incest-like quality of the psychother- apeutic setting and ensures that there is a third party observing the process.[4] Indeed, the therapist "carries" the consultant into the session as an internal presence with whom the therapist can undertake an internal dialogue.

A myriad of reasons can be marshaled to avoid consultation. It is expensive. It takes time away from one's practice. A consultant cannot possibly understand the full complexity of a particular patient. The confidentiality of the patient might be breached if the consultant figures out who the patient is. Many of these excuses are fueled by a wish to have an exclusive "one and only" relationship with the patient, uncontaminated by outside interference.[5]

As valuable as consultation can be, it is by no means a panacea. Consultation or supervision can be corrupted. The corruption can begin with the selection of a consultant. Therapists who wish to continue their descent down the slippery slope can pick friends whose opinion can be anticipated in advance. Therapists select such consultants because they know that nothing they are doing will be challenged. Therapists can also corrupt the consultation process by concealing details from the consultant. I am aware of one situation in which a therapist was having regular sexual relations with a patient but confined what he told the consultant to "struggles with countertransference."

Two basic axioms of prevention can be gleaned from these concerns[4]:

• Anything you are doing with a patient in psychotherapy should be something that can be freely shared with a consultant; if you feel you cannot share what is going on in the psychotherapy with the consultant, then you have already started your descent down the slippery slope.
• Anything you feel that you must keep secret from a consultant is exactly what you should be sharing with the consultant.

Sexual boundary violations often involve a compartmentalized sector of the psyche. Forbidden and otherwise unacceptable activities operate only within this split-off area of the self, while more acceptable professional conduct holds sway with the other patients in the therapist's caseload. The beginning of this compartmentalization process is characterized by concealing certain kinds of interventions or behaviors from a consultant or supervisor.

Different models of consultation exist. Some therapists prefer to meet in groups, where the group itself serves as a consultation process. Each therapist in turn presents at a regular meeting of the group, often at breakfast or dinner. Some colleagues prefer a one-to-one relationship with another colleague, where they alternate presenting cases so that the vulnerability of feeling embarrassment or shame is lessened. An asymmetrical consultation relationship, in which one person always presents, is preferred by some for whom the shame issue is not as relevant, or where there are substantial differences in terms of experience. When therapists are extremely concerned about confidentiality because their patients may be in the mental health profession or otherwise well-known, they can seek consultation with a colleague from another city over the telephone while keeping the identity of the patient confidential.

Institutional settings

Psychotherapists who work in institutional settings must be carefully screened before being hired. Letters of recommendation are often generic and rarely useful in screening out seriously corrupt behavior. Screening persons for a history of criminal behavior or previous ethics violations must be undertaken through appropriate Internet sources, such as the National Practitioner Data Bank for

physicians.

Psychiatric institutions must also have clearly written policies that demarcate appropriate professional boundaries and identify problematic dual relationships. Educational meetings must occur on a regular basis with institutional therapists. Finally, administration must be able to make appropriate interventions early in the process of a boundary transgression rather than waiting until the damage has been done.[2]

Personal therapy or analysis

Psychotherapists must have a working knowledge of their own conflicts, defenses, schemas, internal object relations, and vulnerabilities. Without this knowledge they are at risk for enacting their own needs and wishes with their patients. Hence, most therapists seek out personal therapy or analysis at some point in their professional development. No amount of treatment is foolproof as a form of prophylaxis against boundary violations, but at its best, the therapist's personal treatment experience sets in motion a process of self-analysis that becomes part of his or her professional life.

Conclusions

The foregoing discussion reflects the inherent problem in all preventive efforts—namely, much of the prevention of professional boundary violation relies on rigorous self-monitoring by psychotherapists themselves. This self-scrutiny involves balancing one's life so that one's emotional needs are met in the context of personal relationships in one's private life. While there are a variety of gratifications in doing psychotherapeutic work, they cannot take the place of valued intimate relationships outside the therapeutic setting. Another part of the monitoring must be systematic questioning of oneself: Is what I am doing part of a carefully thought-out treatment plan within the community standards of psychotherapeutic practice? Is anything I am doing potentially exploitative of the patient's vulnerability? Is there anything I am doing that I could not share with a colleague? If we expect our patients to look unflinchingly into the darkest recesses of their psyches, then we must be willing to do so ourselves. At the end of the day, therapists are there to help their patients, and that unassailable ethical principle must be the beacon that guides us.

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