

BOUNDARIES – ACROSS THE BORDERLINE?

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STRUCTURE OF THIS DISCUSSION

- Definitions
- Boundary issues and examples
- Some data
- Are we colluding structurally? Clinically?
- Management options
- Discussion

DEFINITIONS (from Gutheil and Gabbard, 1998)

- **Boundary:** “...the ‘edge’ of appropriate behaviour.”
- **Boundary Crossing:** “...a *benign* variant [of a boundary transgression] where the ultimate effect ... may be to advance the therapy in a constructive way that does not harm the patient.”
- **Boundary Violation:** “...where the transgression is clearly harmful to or exploitative of the patient. In contrast to boundary crossing ... [it] is usually not productively discussed by the therapist and patient and may also be part of a repetitive practice. The harm may range from wasting time and therapeutic opportunity to inflicting severe trauma.”

BOUNDARY ISSUES

- Are manifestations of “Dual Relationships”
- “A dual relationship exists when the provider serves two professional roles, or when the professional relationship includes certain personal elements” (Plaut, 1997). In this sense, a dual relationship is a violation of a fiduciary relationship.
- A fiduciary relationship is “a special relationship in which one person accepts the trust and confidence of another to act in the latter’s best interest” (Feldman-Summers, 1989)
- “The need of the client to trust the professional puts the fiduciary in a position of power, and along with this power must go the obligation to control the boundaries of the relationship” (Plaut, 1997).

Examples Include (but are not limited to):

- Blurred distinctions between being a friend and being a health provider
- Forming sexually intimate relationships in treatment
- Meeting clients/patients socially, unintentionally and intentionally
- Offering other kinds of services to a patient you are not licensed to provide
- Failing to keep your private life out of work
- Accepting gifts
- Personal disclosure to clients/patients
- Undue flexibility over appointment times
- Identifying versus empathising
- Stepping outside the professional role

POSSIBLE CONSEQUENCES OF DUAL RELATIONSHIPS

- Confusion over roles and identity
- Feelings of betrayal of trust
- Depression
- Dependency
- Loss – or the threat of loss – of primary relationships
- Loss of self-esteem
- Loss of livelihood
- Suicide

AND YET...

- What about the continuum of intimacy (support, disclosure, touch)?
- Professional 'demand characteristics' and legitimate professional variability?
- Situational and field elements (e.g., HIV and partner notification)?
- Culture (goods or intimacy exchange as a therapeutic vehicle)?
- Time's winged chariot ("Okay, can I see you in two years...")?
- Context?

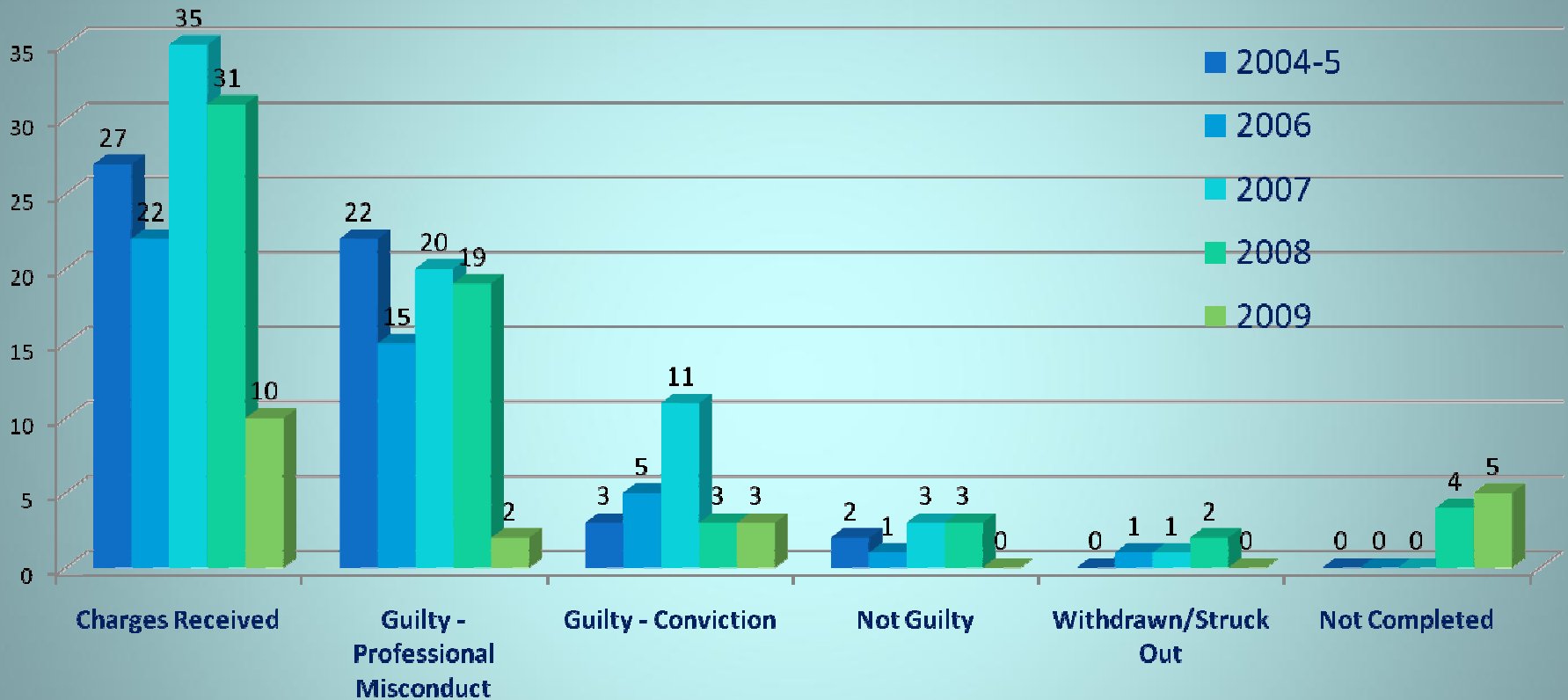
REPORTED NATURE AND EXTENT OF BOUNDARY VIOLATIONS

- 5-10% of licensed psychotherapists have admitted to involvement with at least one patient in their career
- 9% of non-psychiatrist physicians have admitted at least one sexual relationship with a patient (Gartrell et al, 1992)
- Violations between male providers and female clients account for 90% of cases

BUT (Plaut, 1997):

- Only a minority of cases are actually reported
- Clients often do not believe their complaints will be taken seriously by those who will hear them
- Until relatively recently, codes of ethics were very diverse in their articulation of boundaries

NZ Health Practitioners Disciplinary Tribunal Statistics – All Professions 2004-9*



*Dentists (N=4, 3%), Medical Practitioners (N=32, 26%), Midwives (N=4, 3%), Nurses (N=61, 49%), Occupational Therapists (N=2, 2%), Osteopaths (N=1, 1%), Pharmacists (N=9, 7%), Physiotherapists (N=4, 3%), Psychologists (N=7, 6%; 5 were boundary issues)

WHY IS THERE A GREATER RISK IN OUR WORK?

- Therapeutic isolation, despite constant reminders
- Length and intensity of therapeutic relationships
- Psychological vulnerability and awareness
- Transference
- We're there to talk about sex, drugs and death
- Prior histories may engender confusion about appropriate roles and behaviour of authority figures

ARE WE REALLY HELPING? – THE CONTEXT OF GUM/HIV INVOLVEMENT (Gessler et al, 1996)

- GUM services in the UK are separated by an act of Parliament
- Confidentiality is absolute and organisationally isolating
- GUM norms in discussion of sex and sexuality differ
- GUM services surrender conventional defensive structures:
 - Patient choice
 - Patient input
 - First names
 - Dress and accessory codes
 - Shared social circumstances
 - Non-judgementalism
 - Transactional relationships and activities

- Psychosocial emphasis
- Open access – HIV opens all doors with confidentiality
- Fast-track interventions compared to sister services
- Normalising adjustment processes to HIV reduced pathologising of HIV behavioural responses
- Eased manifestations of splitting and rejection between staff and organisations
- Risk of multiple and inappropriate psychological and/or drug interventions and an escalation of secondary iatrogenic phenomena

MANAGEMENT OPTIONS

- Recognise CONTEXT: “When doing that which cannot be discussed, place that which cannot be described over that of which it is forbidden to speak...”
- Discuss boundaries with clients and supervisors
- Professional review, education and training:
 - Motive evaluation and decision-making (Pope and Keith-Spiegel, 2008)
 - Role and work clarity
 - Recognition of client and provider risk factors
 - Learning how to respond to inappropriate behaviour
 - Client/patient education about options and remedies
 - Maintaining rational awareness, humanity and professional discipline (“When in doubt, be human” – Karl Menninger)

DISCUSSION QUESTIONS

- What critical questions need to be asked to ensure organisations do not make boundary violations inevitable?
- When should they be asked, and of whom by whom?
- What are the priority questions and responses for organisations in which boundary tensions are already present?

