CHAPTER 1

Definitions and Dilemmas

"What does all this have to do with me?" you might ask. "Why do I need a book about understanding and maintaining therapeutic boundaries?" After all, you might think, "This couldn't happen to me. I'm not one of those 'bad apples' who give the profession a bad name by exploiting patients. I'm an ethical practitioner, and I've been doing this work for too long to be susceptible to that kind of thing."

In fact, the pitfalls of boundary maintenance do not just confront manipulative predators or the very inexperienced. The vast majority of practitioners who encounter perplexing boundary questions are not 'bad apples,' but mainstream professionals from a range of fields and orientations who find themselves up against the exigencies of daily practice. Unprepared by training, overwhelmed by personal vulnerability, ambushed by circumstance, lulled into complacency by high professional attainment—in one way or another they are "in over their heads." Boundary violations do not necessarily arise from bad character, as Gutheil and Gabbard (1993) point out: "Bad training, sloppy practice, lapses of judgment, idiosyncratic treatment philosophies, regional variations, and social and cultural conditioning may all be reflected in behavior that violates boundaries" (p. 189). In this real, messy world where boundaries may be less clear than they seem, many unsuspecting clinicians may regret having thought *"This couldn't happen to me"* (Norris, Gutheil, & Strasburger, 2003).

> A patient told her therapist, "We'll have to stop our sessions because my husband is being transferred to Los Angeles." From the informa-

tion revealed by the patient, the therapist concluded that her husband's company's stock would rise in value. The therapist then bought a large amount of the stock. In addition to facing professional sanctions, he was prosecuted for insider trading.

At a summer barbecue a therapist noticed that one of his patients had arrived with his family. The therapist wondered whether it would be most appropriate to leave immediately. Then again, he was tempted to stay and gather data about the patient that could be useful for the therapy. "This is a new perspective from which to look at this patient," he thought, "and I don't know much about his family. I can talk to his wife and kids and find out what this is really all about."

A therapist was caught by surprise when a patient suddenly hugged her on her way out at the end of a session. By the time she thought about what she might say, the patient had left the office. The therapist had had enough exposure to boundary issues to feel uncomfortable about what had happened but not enough to know what to do about it, either at the time or thereafter. So she left the issue undocumented, unexamined, and unresolved. Some weeks later she received a letter from the patient's attorney.

Some therapists commit clear improprieties, and some are predatory individuals who should not be practicing. Far more common, however, are conscientious professionals caught in clinical dilemmas that turn into ethical and even legal problems. In many cases a clinician is genuinely uncertain about what is the right thing to do. Often, too, unrealistic expectations or irrational inferences lead a patient to misconstrue normal professional behavior as intrusive or disrespectful.

Boundaries are often subtle and difficult to discern, and the answers to clinicians' dilemmas are not cut-and-dried (see Glass, 2003). Indeed, these answers can vary greatly with circumstances. Some of the cases heard by the courts or boards of registration have come about because of inexperience, inadequate training, or life crises on the part of clinicians. Others are rooted in the clinical dynamics of patients whose suggestibility is touched off by the media or for whom accusation becomes a shortcut to resolution. Often there is an interaction between the two: patients can provoke or misinterpret, but therapists are not always equipped to deal with such problems in the most professional manner. In this uncertain atmosphere, clinicians struggle to maintain a professional demeanor, to do their best on behalf of their patients, and to avoid having questions raised about their conduct even when they have acted in an entirely proper manner.

The following perceived boundary violations represent a spectrum

of formal complaints brought before the American Psychiatric Association ethics committee (J. Lazarus, 1993):

- Therapist accepting gifts from patient
- Therapist taking patient to lunch
- Therapist giving patient a ride home
- Therapist using insider information obtained from patient
- Therapist accepting a party invitation from patient
- Therapist asking patient for advice
- Therapist giving patient gifts in return for referrals of other patients
- Therapist hugging patient
- Therapist making personal revelations to patient
- Therapist writing introduction to patient's book lauding the therapy
- Therapist introducing own children to patient
- Therapist joining patient's book discussion group

The authors' forensic experience and reports in legal publications indicate that other mental health professionals face similar accusations. Questions and conflicts surrounding these and other therapeutic boundary crossings can be stressful for both patient and therapist. They can have serious consequences for the therapy and for the patient's well-being as well as legal and professional consequences for the therapist (extending to loss of license and livelihood). How can the practicing clinician prepare to cope with such questions?

DOING THE LAUNDRY: THE IMPORTANCE OF CONTEXT

When, if ever, is it appropriate for a patient to do a clinician's laundry? This question can serve as a *gedanken* ("thought") experiment to introduce the subject of clinical boundaries. The idea of a patient's being given dirty clothing to handle will strike most people as inappropriate, a clear boundary violation. That is a reasonable reaction, provided that the contract for therapy is to explore the patient's way of living and any symptoms of psychiatric disorders the patient may have. Within this contract, it is difficult to see how the patient's performing personal services for the therapist serves a therapeutic purpose. Indeed, such an arrangement is likely to contaminate the therapy and exploit the patient for the therapist's benefit (Hundert & Appelbaum, 1995).

Now, put the laundry question into some different contexts. First, handling dirty laundry might be part of an exposure exercise in exposure and response-prevention treatment for obsessive–compulsive disorder. Next, suppose the patient is living in a residential rehabilitation program where the goal is not simply personal growth and development but learning to survive through cooperation with others in a communal setting. The house leader performs some therapeutic functions but also structures and participates in the daily life of the community. Chores are allocated equitably for the benefit of all. Here the patient has made an informed choice, in the form of a contract, to live and share domestic responsibilities with fellow residents, including the clinician. Therefore, doing the clinician's laundry, along with everyone else's, is not automatically a departure from the therapeutic contract.

Finally, consider a patient who is being treated by a cognitive-behavioral therapist for intense fear in public settings. In keeping with the plan outlined at the beginning of treatment, the patient is to complete the therapy by going through a fear-inducing real-life situation in the presence of the therapist. If going to the laundromat has been a difficult task for the patient, the therapist might propose, "I'll walk you through going to the laundry, negotiating the various steps in the process." To accomplish this, the patient may bring in a bag of laundry, or the therapist may provide a dirty sweatshirt as a training tool. Either way, *the purpose is to benefit the patient,* not to promote personal intimacy between patient and therapist or to secure unpaid labor for the therapist. Doing laundry together in this structured way is within the boundaries of the treatment for which the patient has contracted.

BOUNDARY CROSSINGS

A *boundary* is the edge of appropriate behavior at a given moment in the relationship between a patient and therapist, as governed by the therapeutic context and contract. It may be defined by the physical, psychological, and/or social space occupied by the patient in the clinical relationship. Where the boundary line actually falls, or is perceived to fall, depends on the type and stage of therapy and may be subject to judgment and interpretation. Therapeutic boundaries are not hard-and-fast. Rather, they are movable and context-dependent, and their placement depends on a number of factors in the clinical situation. Both the flexibility of therapeutic boundaries and the limits of that flexibility can be understood by exploring the nature and significance of boundary

crossings, as distinct from boundary *violations* (Glass, 2003; Gutheil & Gabbard, 1993, 1998).

A boundary *crossing* is a departure from the usual norms of therapy, that is, the verbal and physical distances normally maintained in a therapeutic interaction. It frequently happens that, intentionally or not, a clinician interacts with a patient in a way that is unusual or uncharacteristic of standard psychotherapy. We will use the term "boundary crossings" to refer to benign deviations from standard practice, those that are harmless, are nonexploitative, and may even support or advance the therapy. Examples include extending a hand to help a patient who has stumbled and fallen, giving a ride to a patient who is stranded in a blizzard, and giving a patient (based on need) a number for reaching the therapist in an emergency. If a patient comes into the office sobbing because she has just been informed of a sudden death in her family, withholding the human gesture of accepting the patient's embrace would likely be hurtful and might endanger the therapy. As Karl Menninger is reputed to have taught, "When in doubt, be human."

A RIDE IN A BLIZZARD: MANAGING A BOUNDARY CROSSING

A patient is left stranded after a therapy session by a severe, unanticipated blizzard that has shut down public transportation and made walking hazardous. As the therapist begins to drive home, she sees the patient struggling in the snow. Should the therapist offer the patient a ride?

As a rule (with exceptions such as exposure exercises in CBT), interactions between patient and therapist take place only in the office and are limited to the content of therapy. At the same time, effective therapy presupposes having a live patient. Humanitarian concern and common sense call for coming to the patient's rescue in an emergency. However, this entails crossing a well-established clinical boundary of meeting only in the office. The therapist can manage this excursion in an above-board, professional manner by observing the following guidelines:

1. Behave professionally while in the car together. Do not engage in personal revelations or exchanges that would be inappropriate in the office.
2. Do not attempt to conduct therapy outside the office. The drive home should not be a continuation of the office hour.
3. Document the boundary crossing as relevant data. Have it on re-

cord that the therapist exercised clinical judgment and considered the possible impact of the incident on the patient and the therapy.
4. At the next office session, debrief the patient and open up the incident for exploration.
5. Make note of the boundary crossing in supervision. A therapist who is not in regular supervision should obtain a consultation if anything about the incident appears to present special problems for the patient or for the therapist. This step is especially important if the therapist becomes aware of a reluctance on his or her part to document the incident.

If an interaction with a patient feels like something that cannot be written down as part of the therapeutic record, it is a potential problem. If it cannot be brought back to therapy and discussed with the patient, it is a potential problem. The same is true if it cannot be submitted to the informed judgment of a colleague or supervisor. These principles of good clinical practice would apply even if there were no legal or professional sanctions to fear. In addition, if these precautions are not taken, a subsequent review may conclude that the therapist tried to cover up a misjudgment or impropriety. This clearcut example of professionalism does not resolve all the complexities presented by therapeutic boundaries, but it points the way to coping with those complexities ethically and effectively.

Psychoanalytically trained therapists view boundary crossings as an inevitable manifestation of the shifting distance between therapist and patient in the course of the therapeutic encounter. By processing these crossings with the therapist, the patient learns to question habitual assumptions and behavior patterns. Cognitive-behavioral therapists address boundary crossings (referred to by Linehan, 1993, as "in-session behaviors") in an analogous way. Practitioners need to be alert to the occurrence of boundary crossings that may raise clinical, ethical, or legal questions and be prepared to process them therapeutically, both for the patient's benefit and to minimize the risk that a boundary crossing may turn into a boundary violation.

BOUNDARY VIOLATIONS

Some boundary *crossings* are inadvisable because of their intent (i.e., they are not done in the service of the patient's well-being and growth and involve extratherapeutic gratifications for the therapist) and/or their effect (i.e., they are not likely to benefit the patient and entail a significant risk

of harming the patient). Such unwarranted and dangerous crossings, which essentially exploit the patient, are called boundary *violations*. A boundary *violation* is a boundary crossing that takes the therapist out of the professional role. Violations are typically exploitative or done for the therapist's rather than the patient's benefit, and they have a potential to harm the patient. Indeed, good intentions will count for little in subsequent forensic evaluations if the therapist's actions are found to have had a foreseeably harmful impact (especially on a previously traumatized patient).

As will be shown in Part II, boundary violations can range from seeing the patient at an inappropriate time or place to having a social, financial, or sexual relationship with the patient. Whereas either the patient or therapist can initiate a boundary crossing, the word "violation" implies the transgression of an ethical standard, a judgment that is made only about the therapist. A patient may initiate behavior that presents a serious threat of a boundary violation, such as disrobing in the office or impulsively kissing the therapist. However, since the therapist retains responsibility for maintaining boundaries, whether this provocative behavior leads to a boundary violation actually depends on the therapist's response.

Unfortunately for the well-meaning clinician, it is not always possible to avoid boundary crossings simply to avoid any chance of committing a boundary violation. Psychoanalytically oriented therapy, for instance, is conceived theoretically in terms of how the patient and therapist approach and retreat from boundaries and how they negotiate the boundary crossings that inevitably occur in this process. Such crossings and negotiations occur, and are appropriately recognized, in other types of therapy as well (see Kohlenberg & Tsai, 2007; Leahy, 2001, 2003b; Linehan, 1993; Safran & Segal, 1996).

Whether a given act constitutes a boundary violation can rarely be assessed outside of the therapeutic context in which the act takes place. The exceptions are egregious instances such as sex with a patient and insider stock trading based on a patient's revelations. Rather, clinical boundaries are set by the therapeutic contract, which limits the types of interactions the patient and therapist will have in the service of a stated therapeutic goal. (The therapeutic contract is discussed in greater detail in Chapter 3.) It is in this context-driven framework that boundaries either are or are not crossed or violated. A key question to ask in considering possible boundary violations, before or after the fact, is *"Cui bono?"* (For whose benefit?). If it is demonstrably *for the patient*—that is, for the health or benefit of the patient—it is at least presumptively within the boundaries of therapy.

BOUNDARY VIOLATIONS AND RESPONSIBILITY: THREE AXIOMS

The word "violation" necessarily raises questions of accountability. Who is responsible for transgressing the permissible limits of therapeutic exchange? If the patient initiates the transgression, is the patient at fault? These questions are especially urgent in a political atmosphere in which any acknowledgment of the patient's contribution to and participation in an extratherapeutic interaction with a clinician has been referred to as "blaming the victim." This critical issue will be discussed more fully in Chapter 11. Here, we present three axioms developed by the authors as ground rules for discussion and analysis (Gutheil & Gabbard, 1992, 1993). These fundamental principles make clear that seeking to understand the etiology of boundary violations is not the same as condoning or excusing them.

> **Axiom I:** *The responsibility for setting and maintaining boundaries always belongs to the clinician. The patient is not blamed or stigmatized for violating therapeutic boundaries.*

Only the clinician has a professional code to violate; the patient has no such code. Therefore, only the clinician can be culpable, blameworthy, or subject to civil or (in some states) criminal liability. This is true even if (as is often the case) the patient initiates the boundary challenge. Does the patient have any boundaries to maintain? Although the patient does in fact join the therapist in establishing the therapeutic frame (Spruiell, 1983), the patient's boundaries are more flexible and forgiving (Gutheil & Gabbard, 1993). As one senior clinician puts it: "There are three rules of therapy. You come on time. You pay your money. And we treat each other with respect. Everything else is negotiable" (C. Gates, personal communication, 1968). Indeed, one might question whether the patient even needs to come on time. The therapist should not be late, but if the patient is willing to pay the full fee for less than a full hour, the meaning this behavior has for the patient can be explored.

Of course, the patient cannot be allowed to assault the therapist physically. Indeed, the immediate need to restrain the patient may necessitate physical contact that would otherwise be a boundary violation. With that major exception, enactments, or actions, that would be unethical on the part of a therapist become, on the patient's part, material for therapy. Subject to no code, the patient is free to request, demand, pout, or vent. The patient can call the therapist "Shrinkie," make flirtatious gestures, or threaten to discontinue therapy or commit suicide.

A patient who asks a therapist to have sex is not violating any ethical code and is not punished. Rather, the therapist sets limits ("that's not therapy") and explores the meaning of the patient's wish for sex with the therapist. If the patient persists in propositioning the therapist over a long period of time, as with any other unproductive behavior, questions can be raised about the progress and effectiveness of the therapy. Such questions are to be resolved (usually with a consultant) by the usual criteria for redirecting or terminating therapy.

> **Axiom II:** *In any interaction between two people, the actions of both play a contributing role. However, by Axiom I, the fact that the therapist and patient are in that sense responsible for their actions cannot be translated into blaming the patient/victim.*

Any interaction does have two sides. A competent adult patient is accountable for his or her actions (even if, in a psychoanalytic model, driven by unconscious forces) in the very general sense that we are all responsible for everything we do. But the moral equality, or role symmetry, between patient and clinician ends there. Entering into the therapeutic relationship for different purposes, the two parties have unequal power and responsibility within that relationship. The clinician has a fiduciary responsibility to safeguard and promote the well-being of a vulnerable patient. Therefore, to analyze boundary violations as complex interactions between two people that reflect a variety of dynamics on both sides in no way blames the patient or relieves the clinician of responsibility.

Humbert Humbert's plea for understanding in *Lolita*—"She seduced me!"—is no defense for a therapist who has sex with a patient, even if she *did* seduce him. Part of a clinician's job is not to be seduced; the patient has no such job description. It is only to be expected, not condemned, that patients will initiate a good many boundary crossings. These crossings are predictable expressions of the problems for which patients seek treatment, and patients often rationalize them as such. But therapists must not meet patients' rationalizations with their own (e.g., "I'm giving this patient the relationship she needs"). Rather, they need to keep in mind that the processes begun by patients' boundary crossings are a normal and—if skillfully handled—beneficial part of therapy.

> **Axiom III:** *Careful, candid, clinically informed exploration of professional misconduct, with attention to actual cause-and-effect relationships, will, in the long run, be beneficial to patients, illuminating to the mental health professions, and valuable to society.*

Various factors appear to have contributed to the current disinclination to study the therapeutic dyad as the fertile ground from which boundary violations grow. On one side, there is the insistence on political correctness that sees any examination of the patient's contributing role in the situation as an attack on the patient, inflicting added trauma on an already devastated victim (Gutheil & Gabbard, 1992). On the other side, at least within psychiatry, there has been less effort to understand the interaction between therapist and patient during a time when a more straightforward medical model of treatment has gained ascendancy (Schultz-Ross et al., 1992). The result has been the common division of labor in which the psychiatrist dispenses medication while other practitioners assume responsibility for the patient's psychotherapy, with its inevitable relational features (outlined in, e.g., Norcross, 2002; Safran & Muran, 1998, 2003; Wachtel, 2007).

Rigorous empirical study will offer the most reliable route to effective preventive strategies (see, e.g., Twemlow, 1995a, 1995b, 1997). Such exploration will not necessarily be pleasant, comfortable, reassuring, or politically palatable. Nonetheless, we must face what really is before us if we are to have any hope of reducing the incidence of serious boundary violations without extinguishing the creativity and spontaneity of therapy.

Following these axioms, the case vignettes in this book are presented with full attention to the relevant dynamics of the dyad but with a clear emphasis on the clinician's ethical responsibility. The following case is illustrative.

> A woman in her late 20s who complained of depression and troubled relationships had been seeing a male therapist for several months. During one session she asked the therapist if she could take off her clothes to relax. In the complaint she later filed with the licensing board, she stated that the therapist had simply replied, "It's your session." In his version of the story, the therapist claimed that he had said nothing. Paralyzed by helplessness, dismay, and dread in a situation he had never before faced, he watched helplessly as the patient stripped to the waist. He then ran into the adjoining office and searched desperately for the applicable code in a book of regulations.
>
> This patient had already crossed boundaries with the therapist by appearing at public events in which he was involved. She was simultaneously seeing a female therapist, whom she accompanied on shopping trips as well as to the therapist's medical appointments. The second therapist was prescribing medications for her. Neither therapist knew about the other.

Patients do initiate or provoke boundary violations. This patient drew two therapists into a web of manipulation and enmeshment. She sought to reassure herself that she had the upper hand in knowledge and power. A highly publicized "crackdown" on boundary violators gave her a way to exert further control by embroiling one of the therapists in a complaint process. Although this was, on the surface, what she wanted, it was not what she (or her insurer) was paying for. Therapeutically, her behavior might have opened a window on the way she dealt with people outside of therapy, but she needed a therapist to open that window for her. Both therapists, by their failure to set limits, served her ill. By allowing her to act out in her habitual ways, they did not help her confront the sources of her behavior and learn to deal differently with her feelings. That clinical failure is their responsibility, not hers.

Preventive and remedial strategies for this kind of situation, including how the therapist might better have reacted to the unanticipated emergency, will be considered in Chapter 7. The therapist did not intend or initiate misconduct, but in his understandable discomfort he was unprepared to respond to the challenge in a professional manner. In the stress of the moment he took refuge in a book of regulations. Concerned first to protect himself from possible sanctions, he neglected to attend to the patient clinically. His ill-considered reaction exemplifies the harm done by a messianic crusade against boundary violations that ignores critical contextual factors as well as essential distinctions as to the type and severity of boundary crossings.

REALITY VERSUS PERCEPTION OF MISCONDUCT: THE "SLIPPERY SLOPE"

An important concept in boundary theory is the so-called slippery slope that leads incrementally from minor boundary crossings to more serious violations, often culminating in sexual misconduct. This metaphoric image has been under attack as too alarmist and as unnecessarily stigmatizing (by association with sexual misconduct) with respect to small, innocent, and sometimes beneficial deviations from standard practice. The criticism will be discussed and the "slippery slope" reinterpreted in less rigid, more reasonable, terms in Chapter 11. It is useful at the outset, however, to establish some guidelines for understanding.

First, sexual misconduct on the part of a clinician usually is preceded by relatively minor boundary excursions. It is a common pattern, and it does get people in trouble. There can be little doubt that a therapist who

allows—let alone asks—a patient to disrobe during a session is at increased risk for progressing to sexual misconduct. However, not all boundary crossings or even boundary violations lead to sexual misconduct (in fact, most do not), and by themselves they do not constitute evidence of sexual misconduct. Rather, the "slippery slope"—as a legal term applied to a clinical situation—more often describes the law's *perception* of the progression of boundary violations than it does the reality. However unfairly, juries, judges, ethics committees of professional organizations, and state licensing boards often believe that the occurrence of boundary violations, or even crossings, is presumptive evidence of, or corroborates allegations of, sexual misconduct (Gutheil & Gabbard, 1993).

Where therapists do proceed down the "slippery slope," it is often through a combination of rationalization, blackmail, and fatalism. Initially, the boundary transgressions may be sufficiently small that the therapist can rationalize that nothing out of the ordinary or potentially harmful is happening. Then the patient drops the other shoe: "OK, you've been hugging me. Now it's time to take the next step." "Now, I can't possibly refuse," thinks the flustered, intimidated therapist, "because then the patient will get angry and file a complaint about the hugging." (See Chapters 8 and 11 for further discussion of such situations.)

It is prudent, therefore, to pay attention to the flow of actual and potential boundary crossings in your practice. If there is any ambiguity about the appropriateness of your treatment, a blurring of boundaries may be taken as a sign of substandard treatment in the event of a lawsuit resulting from a bad outcome. And if you are accused of sexual misconduct, the fact finder may take the position that a lesser boundary violation lends credence to the allegation.

For clinical, ethical, and legal reasons, clinicians of all disciplines should be alert to the dynamics of any therapeutic encounter and any ongoing relationship with a patient, and keep their eyes and minds open to possible motivators and precipitants of boundary crossings in the patient, in the clinician, or in the interaction. Ideology and good intentions can subvert good practice if they prevent one from attending to the turbulent complexity of a patient's psyche or the demons and temptations that beset one's own.

WHEN DOES A BOUNDARY CROSSING BECOME A VIOLATION?

How can you tell when a boundary crossing becomes or risks becoming a boundary violation? Sometimes a crossing takes on the character of a vio-

lation when it is part of a repetitive pattern or is followed by more overt boundary violations. When an individual act is looked at in isolation, the judgment depends on clinical considerations. Was the act in question undertaken in the interest of the patient? What effects might it have on this particular patient? Did the therapist deal with the crossing in an ethical, professional manner?

Answering these questions requires posing more questions. What, in a particular exchange between two particular individuals, does it mean to act in the patient's interest, to anticipate possible effects on the patient, or to respond in a professional manner? One useful guideline is that a boundary crossing is more likely to be benign if it is discussible and is in fact discussed with the patient (and, if called for, with a supervisor or consultant). A therapist who, instead of acting in an oblivious or self-protective manner, works through such an incident with the patient is acting to restore the professional role and repair the relationship. Moreover, clinical exploration of a potential or inadvertent boundary violation often defuses its potential for harm and may benefit the patient and advance the therapy.

The character and significance of a boundary crossing are highly context-dependent (Gutheil & Gabbard, 1998). One context that needs to be taken into consideration is professional discipline. A CBT practitioner who accompanies a patient out of the office for the purpose of encountering a feared situation and a case manager who makes home visits to give a patient practical assistance are acting within their defined, theoretically based professional roles, which are not the same as that of a psychoanalyst when it comes to out-of-office contacts. Boundaries can also shift with changing treatment practices and settings. For example, in the era of extended inpatient treatment, therapists commonly conversed with their patients during leisurely walks on the hospital grounds; this gave many patients a feeling of comfort, safety, and peace. In today's more impersonal hospital settings, patients and clinicians often are not together long enough to get to know each other and so taking a walk outside the hospital with a patient is more likely to be seen as problematic. Other relevant contexts include the therapeutic task at hand, the therapist's style and approach, the patient's needs, the stage of treatment, and the options and constraints presented by the geographic and community setting (Simon & Williams, 1999).

A critical context is that created by cultural differences. To take a historical example, an Austrian psychoanalyst who immigrated to the United States found that he needed to stop helping female patients put on and take off their overcoats. In his native Vienna he would have been considered rude had he neglected this routine courtesy. In the United States,

however, a vulnerable patient might develop erotic feelings toward the analyst on the basis of this minimal physical contact, and a gesture taken for granted in other cultures (or in previous eras) might be misconstrued as a boundary violation not only by the patient but also by a jury or regulatory board. To take a contemporary example, a Brazilian immigrant patient for whom incidental physical contact would seem customary and normal might find a therapist's display of diplomas on the office wall (taken for granted in the United States) pretentious and off-putting (Miller et al., 2006).

As this example illustrates, the significance of a boundary crossing is to be found in "the psychological meaning of the event to the patient and the therapist" (Waldinger, 1994, p. 225). For the Austrian analyst, helping patients on and off with their coats had no special psychological meaning; he was not acting out of neediness, wish for contact, or self-aggrandizement. It was, however, his professional responsibility to discern the psychological meaning that this "innocent" act might have for American women and to change his behavior accordingly. It is a distressing fact of life that patients experiencing the insecurity, anguish, grief, and grievance often associated with psychiatric disorders may interpret the most proper, unobjectionable behavior on a therapist's part as exploitative and harmful. No clinician can anticipate all such delusions that may arise. Nonetheless, it helps to be aware of some common ways in which patients whose own boundary maintenance is weak—such as paranoid patients, those with borderline personality disorder (Gutheil, 1989, 2005b, 2005c), and those who have been abused—can show a hypersensitivity to boundary crossings (see Chapter 10).

Two contrasting cases, described in greater detail by Waldinger (1994), show the importance of personal history and context in how patients react to boundary crossings. In the first case, a 25-year-old woman came to an outpatient clinic complaining of dissociative episodes during a severe economic crisis in her life. Her male psychotherapist agreed to see her without charge, a deviation from standard practice at the clinic that seemed justified by the patient's circumstances. Several weeks later the patient began to express the fear that the therapist was trying to take advantage of her. After a suicide attempt was narrowly averted, the therapist sought consultation. The patient told the consultant that when she was an adolescent her brother had given her gifts in exchange for sex. She feared that her therapist would similarly demand anything he wanted from her in return for free treatment. The consultant then recommended that the therapist discuss the patient's fears in treatment and that he negotiate a small fee with the patient to establish a clearer boundary.

In the second case, a 46-year-old man had been in therapy with a female therapist for 5 years. His main concerns were his troubled marriage and his overly close relationship with his mother. His mother's unexpected death precipitated a suicidal crisis, hospitalization, and divorce. Now living alone, the patient was more dependent on his therapist for support than he previously had been. As he began to reconstitute, he acknowledged how alone he felt and expressed gratitude toward the therapist for her stable presence in his life. At the end of that session, he asked her if he could give her a hug. Caught off guard, the therapist made an on-the-spot judgment that it would harm the patient if she refused. She explored this incident at her next session with the patient, who said the hug had reassured him that "someone could still stand me." Still worried that her maternal feelings toward the patient had drawn her into a boundary violation, the therapist sought consultation. The consultant not only found no evidence that the patient had been harmed, but agreed that it might have hurt the patient to refuse his hug at that pivotal point in his recovery. The consultant expressed confidence that henceforth the patient would be strong enough to discuss rather than enact his yearnings for connection.

In the first of these cases, the patient experienced what the therapist intended as a helpful boundary crossing as though it were a boundary violation. In the second, the patient experienced what would normally be called a potential boundary violation as life-saving support. Thus, the very same act (such as calling a patient by his first name or agreeing to schedule more frequent sessions with a patient) may turn out to be either a boundary crossing or a boundary violation, depending on the contexts in which it occurs. Waldinger (1994) summarizes the practical significance of the two cases as follows:

> Both therapists had departed from their standard practices with patients—a clear indication for self-examination and consultation. If these examples had occurred in psychopharmacological treatment or cognitive therapy, the need for consultation would have been just as great. (p. 227)

Both therapists saw the need for self-examination and consultation. Not coincidentally, although both patients had been suicidal, neither case resulted in lasting harm to the patient, and neither led to a lawsuit or an ethics complaint. Indeed, the great majority of therapists' deviations from their usual practice do not result in boundary violations, let alone malpractice suits or complaints to licensing boards. Nonetheless, any devia-

tion from standard practice warrants reflection as to the clinical rationale for the action being taken and any warning signs of a boundary violation (see Chapter 13).

Boundary questions arise in a number of areas, including gifts and services, modes of personal address, various forms of self-disclosure, times and places for therapeutic interactions, accidental and deliberate contacts outside the office, billing practices, and physical contact. Which professional responsibilities carry over to a clinician's personal time outside the office, and which do not? A therapist needs to be attentive to various boundary issues that emerge, as these may facilitate or block the patient's autonomous strivings—in other words, as they present opportunities or pitfalls for therapy. How does one steer clear of inadvisable and dangerous boundary crossings without losing the flexibility needed to support the patient's growth? How can one plan and manage boundary crossings that might help the patient? Finally, how can one best recover from inadvertent or ill-considered boundary crossings, thus preventing the so-called slippery slope of escalating boundary violations that is truly inevitable only when it is presumed to be so?

As the chapters that follow will show, there are basic clinical principles that can guide the clinician through these thickets, even while any given situation may demand its own individualized resolution. Such resolution can be as simple as *"Cui bono?"* and as complex as an unprecedented set of contingencies for which no rulebook, no algorithm, exists. Much of the time, the clinician can go far toward a solution by asking, "Who is this for, anyway? What goals, whose goals, are being served? Is it in the service of the therapy, of the therapeutic contract, and of the patient's autonomy and growth? Am I getting something out of it beyond the satisfaction of a job well done and the experience and wisdom gained from practice?" Protecting the patient from harm and enhancing the patient's welfare are the primary goals, but they must be achieved in a highly charged clinico-legal environment in which the therapist's safety also is salient. Reconciling these sometimes divergent needs and priorities is a challenge to be met through deep understanding and well-developed therapeutic technique.

In the discussion thus far, we have tried to show that clinical boundary questions are characterized by neither rote simplicity nor unmanageable complexity. In many cases it is by no means obvious what is appropriate professional behavior, but there are ways to think about such situations so as to resolve one's doubts reasonably and responsibly. We turn to that in the next chapter.

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