

## Boundary Crossings and Violations in Clinical Settings

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### Abstract

Principles of beneficence, autonomy, and nonmaleficence, compassion along with fiduciary partnership are the core concepts in the doctor-patient relationship in therapeutic settings. There are varieties of reasons for boundary problems. Physicians ignorance, exploitative character, emotional vulnerability moral weakness and similar factors may pave the way for boundary issues resulting in nonsexual or sexual boundary crossings and violations.

**Keywords:** *Boundary crossings, boundary issues, boundary violations*

### INTRODUCTION

Physicians are held in great esteem and respect by the society. It is the duty of the medical personnel to discharge their duties toward the billions of suffering from physical or psychological disorders, with a sense of commitment and without damaging the values of ethics. The behavior of the physicians toward their clients must be consistent in all aspects with the norms of the society and culture they live. Physicians are bound to abide by Hippocratic Oath. The Hippocratic Oath is an oath historically taken by doctors swearing to practice medicine ethically.[1]

The physician must possess the competence or the need to master his task; he must practice the ethical behavior and be able to police his ranks. He must possess accountability and is also accountable to public. Public trust must be maintained. The quality of advocacy and the ability to advocate for physically and mentally ill persons by the physician will contribute to the effective preservation of the public trust that he enjoys.

Social relationships are complex with many levels of interaction. However, a covenant protects the space that must exist between the professional and the client.

This formal agreement controls the power differential in the relationship and “allows for a safe connection based on the client's needs.”[2] Physicians have an ethical obligation to care for all patients with beneficence, nonmaleficence, and confidentiality.[3] Within this privileged and trusted relationship, we must address our patients’ needs instead of our own.

Physicians behavior toward patients should always be initiated and maintained with the patients best interest in mind. The maintenance of boundaries thus helps to preserve the integrity of the relationship and expand the trust the public has in them.

### DEFINITION OF BOUNDARY

A boundary may be defined as the “edge” of appropriate professional behavior, transgression of which involves the therapist stepping out of the clinical role or breaching the clinical role. Boundaries define the expected and accepted psychological and social distance between practitioners and patients. Boundaries are derived from ethical treatise, cultural morality, and jurisprudence. Sometimes, it is difficult to clearly define the perimeter of these boundaries and the integrity of the relationship.[4]

### BOUNDARY ISSUES

Boundary issues are disruptions of the expected and accepted social, physical, and psychological boundaries that separate physicians from patients. The therapeutic relationship between a doctor and the patient is established solely with the purpose of therapy and whenever this relationship deviates from its basic goal of treatment, it is called boundary violation and becomes non-therapeutic. In psychiatry, as the therapeutic relationship is prolonged and more personal as many confidential matters are discussed, there is likelihood of developing strong emotional bonds. This may lead to non-therapeutic activity.[5]

#### Boundary issue types

Two types of boundary issues are identified by Gutheil and Gabbard—boundary crossings and boundary violations.[5] This may result or manifest as non-sexual or sexual boundary crossings and boundary violations. A boundary crossing is a deviation from classical therapeutic activity that is harmless, non-exploitative, and possibly supportive of the therapy itself. In contrast, a boundary violation is harmful or potentially harmful, to the patient and the therapy. It constitutes exploitation of the patient. Similarly, boundary crossings and violation may arise from the therapist or from the patient.

#### Ethical principles in boundary issues

Respect for the dignity of the patient is the fundamental ethical principle in boundary problems.[6] The patient's authentic goals or choices must be respected. The concept of autonomy that is fostering the patient's independence and separateness as a self-directing person, along with promoting the self-determination attitude of the patient form the central core in the perseverance of the boundary concepts. The fiduciary relationship, namely the concept of trust or good faith, must be maintained. A fiduciary in healthcare is one whose actions are worthy of trust. A fiduciary partnership has been described as being characterized by “sincerity without reserve” and “loving care” (Guttentag 1968).[7] Fiduciary rubric components like altruism, beneficence, nonmaleficence, and compassion have to be observed in the treatment setting. The therapist has to observe and see that his personal gain does result in exploitative situation and damage the principles of neutrality and abstinence.

Clear professional boundaries create safety for both patients and physicians as well as for society. Boundaries establish clear roles for physicians and define the therapeutic territory; they do not undermine the physician-patient relationship. If boundaries are ignored, physicians can find themselves acting in their own best interest instead of the patient's best interest.

#### Slippery slope concept

The doctor is responsible for preserving the boundary and he should ensure that boundary violations do not occur. If even a minor violation occurs, it is better to transfer the patient to a colleague. The boundary violation typically starts small and become incrementally problematic and the dyad starts sliding down the slope. This is known as Slippery Slope Concept.

#### Non-sexual boundary issues

The role played by a physician is to be “synonymous with the Hippocratic obligation to act always in the interest of the patients and avoid harming them.” It is essential that the psychiatrist not reverse his or her professional role with that of the patient. Role boundaries may be crisp, flexible, or fuzzy, depending on the role under consideration and on the cultural climate.

The boundary examines the quality and quantity of time spent with the patient. When physicians spend great lengths of time with attractive patients but less with unattractive ones, there is a potential boundary difficulty. Likewise, scheduling patients outside regular hours, giving “special” late appointments, or offering more frequent follow-up than is medically necessary suggests that physicians’ needs are being met before patients needs.

Patients should be treated similarly when deciding where treatment is to occur either in the consultation room, bedside, or if needed at home and must be seen in similar contexts. The place of consultation should be clinic and the time should also be during the consultation hours. If the psychiatrist charges fees, he should keep charges that are reasonable for that area.

It would be difficult to claim that gifts from a physician to a patient are beneficial. The most obvious form of gifts are consumer goods, but there are more subtle “gifts,” such as generous prescriptions or excessively large amounts of drug samples to selected individuals. These medication favors are particularly dangerous with addictive medications, because they place the patient in a dependent position. Likewise, the physicians must relented to accept gift or favors from the patient. Very often, influential people like politicians and government officials may offer special privileges for the doctor or his department, but all such concessions or allurements are also unethical.

Whenever the psychiatrist and the patient start becoming friendly, then the therapeutic relationship is compromised. The objectivity is compromised and factors outside the therapeutic relationship may become destructive to the therapeutic process. Business relationship with a current patient is unethical except when one is living in a small community where such relationship cannot be avoided.

Physicians should avoid seductive or revealing dress when treating patients. Clinical apparel can help maintain the appropriate professional distance between physician and patient. The way the physician addresses his client is most important. Doctor should be dressed formally. Dresses that are flashy or reveal body part in a provocative manner should be avoided. The language used should be formal and abusive or double meaning words should be avoided.

Physicians sometimes reveal increasingly personal details to patients and end up violating appropriate boundaries. Unlike regular social conversation, our main task is to listen, not to talk.

Any clinical decision should be based on what is best for the patient; the physician's ideology should play as little apart as possible in such decisions. The physician may be against inter-religion marriages, but if the patient wants it, then his wishes should be respected.

Touch is an extremely powerful bonding tool, but like most tools, it cannot be used indiscriminately. Though touch is a necessary component of diagnosis and healing in medicine, it can be misunderstood. Physicians must be clear about why touch is necessary.[8]

Boundary issues involve circumstances in which health professionals encounter actual or potential conflicts between their professional duties and their social, sexual, religious, or business relationships.

Health professionals should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. A professional enters into a dual relationship whenever he or she assumes a second role with a client, becoming mental health professional and friend, employer, teacher, business associate, family member, or sex partner.

Conflicts of interest occur when professionals find themselves in “a situation in which regard for one duty leads to disregard of another or might reasonably be expected to do so.” Health professionals should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment.

Boundary issues may thus result or originate from the way in which the physician schedules his working with the client by the time and place of consultations, contacts on phone, in social meetings, etc., or by accepting or giving of gifts, money, or by the types of clothes the doctor wears and the language he uses. Boundary issues involve the therapist's role and his relationship with the patient and his family.[9]

#### Sexual misconduct

Four elements appear in all boundary violations, and these are particularly notable in sexual abuse of patients by physicians. The elements are role reversal, secrecy, double bind, and indulgence of professional privilege.

First, sexual misconduct usually begins with relatively minor boundary violations, which often show a crescendo pattern of increasing intrusion into the patient's space that culminates in sexual contact. A direct shift from talking to intercourse is quite rare; the “slippery slope” is the characteristic scenario. As Gabbard and Simon have pointed out, a common sequence involves a transition from last-name to first-name basis; then, personal conversation intruding on the clinical work; then, some body contact (e.g., pats on the shoulder, massages, progressing to hugs); then, trips outside the office; then, sessions during lunch, sometimes with alcoholic beverages; then dinner; then movies or other social events; and finally, sexual intercourse. Second, not all boundary crossings or even boundary violations lead to or represent evidence of sexual misconduct.[10–12]

### CONCLUSION

It will be apt to conclude with the following remarks by T. L. Beauchamp. “An absolutist position concerning treatment boundary guidelines cannot be taken. Otherwise, it would be appropriate to refer to boundary guidelines as boundary standards. Effective treatment boundaries do not create walls that separate the therapist from the patient. Instead, they define a fluctuating, reasonably neutral, safe space that enables the dynamic, psychological interaction between therapist and patient to unfold.”[6]

### Footnotes

**Source of Support:** Nil

**Conflict of Interest:** None.

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