

Boundaries has its foundation in ethics psychology essay



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When looking to scholarly articles on the issue of boundaries in a therapeutic setting everything seems to lead to sexual misconduct. One could easily be swayed to believe that as long as there is no sexual misconduct there is no boundary violation. Perhaps it is assumed that people have a firm set of boundaries that have been established in their interactions with others that guide their decision making in regards to what is and is not acceptable in a given relationship. Perhaps we are looking for a set of rules that doesn't exist in a standardized set.

The following will briefly outline what can be learned from the supply of journal entries related to this inquiry. Additionally several interviews were conducted to attempt to get a working set of ideas that may clear up the issue of setting personal boundaries in the "caring" profession. Also included will be some personal experiences this writer had while interning at the Bergen County Housing, Health and Human Services Center.

As previously stated most of the articles surveyed dealt with this issue mainly from a sexual standpoint. Detailing various ways in which small violations such as exchanging gifts or meeting a client outside of the workplace is a slippery slope that in the minds of most writers will almost inevitably lead to sexual misconduct or at minimum leave the professional open to suspicion of intended if not outright misconduct. Clearly anytime there is a situation where an impropriety either real or imagined, could possibly occur the utmost of care need be taken to ensure our true intentions are plain and foremost in the interaction.

One thing that is helpful in determining where boundaries are drawn in a clinical relationship is the rules that govern one's scope of practice. These guidelines like a job description give one the limits to what they are required or often even allowed to do. Some things are obvious; the housekeeper in a mental health facility does not administer medication to a resident. Some less obvious, a client in an assistive living situation has an appointment across town and is not feeling up to riding the bus to get there. Does the social worker take them in their car? It is important to consider not only the benefits of an action but also any possible way it could be misconstrued. Most things that don't happen don't happen for a good reason. While it would be a kindness to make this client's life easier by giving them a ride there are legal considerations. What if there is an accident and the client is harmed? Who will be responsible?

In speaking with a practicing clinician about setting boundaries he explained to me that his approach when considering an action to be taken with a client is to draw four boxes and label them as shown on the following page. Above these boxes we place the issue at hand and then list the possible ramifications of taking said action.

After filling in all possibilities the pros and cons of the action and subsequent outcomes are weighed and a best for all involved decision is reached. It is important to note that the concepts of always and never rarely apply to human interaction and most things need to be considered on a case by case basis. Always Do No Harm is a good standard to judge action and inaction on.

Buying Lunch for a Client

Detrimental to Client

Fosters dependence on others rather than developing self-sufficiency skills.

Ect...

Beneficial to Client

Solves the meeting of one basic need and allows for belief that their needs can and will be met by clinician thus strengthening the therapeutic bond.

Ect...

Detrimental to Clinician

Puts clinician in a position to be taken advantage of and possibly lays a foundation for further exploitation by client. Ect...

Beneficial to Clinician

Allows for an expression of caring. Ect...

The big picture goal is a fully developed therapeutic relationship that results in the client becoming as functional as possible. There are many aspects of this development that need to have boundaries established. From things as basic as the client must not only show up for meetings but must be on time and "present". This boundary applies to the clinician as well. Many of the boundaries we set in this type of situation are key to helping the client develop the skills needed to function within society.

An issue that arises is that many clients have an emotional or cognitive deficit that makes boundaries a foggy issue at best. It is very common for mental illness to remove a client's ability to recognize how their actions affect others. This is truly part and parcel of many of the illnesses we as clinicians are trying to guide people through. Firm boundaries are essential to the development of a functional relationship in this setting. Boundaries help to establish methods of caring that serve to both comfort and help the client grow towards better functioning. They can be confounding at times but usually at a place where there is cognitive and or behavioral adjustment needed.

Another function of boundaries set by the clinician is for people who have been abused or neglected, exploited or taken advantage of, is that it allows them to see how they can begin to establish boundaries that help them feel safe and secure in their current relationships.

Treatment boundaries have been conceptualized as a therapeutic frame which defines a set of roles for the participants in the therapeutic process. This therapeutic frame has been described by Langs and others as ground rules for the practice of psychotherapy. (Langs, 1982) This therapeutic frame includes everything from structural elements ie. When, where, and how much, as well as what activity will occur during the therapy sessions. Therapists are generally responsible for constructing and maintaining this therapeutic frame, although it should be considered beneficial that patients also contribute to its development.

There are several key principles that underpin the concept of boundary guidelines in psychotherapy. Foremost, is the principle of abstinence (Simon, 1992). The principle of abstinence tells us that in our interactions with clients we should refrain from self-seeking and personal gratification that is beyond the professional satisfaction derived from being a part of the therapeutic process. A second principle underpinning boundary guidelines is the duty to neutrality (Simon, 1989, 1992). This principle informs us that the client's agenda should always be the main focus of our interactions. We are not to meddle in clients' personal affairs that are outside the therapeutic agenda and to share unsolicited personal opinions in therapy. A third principle states that clinicians must always strive to enhance a client's autonomy and independence (Simon, 1992). Proper maintenance of treatment boundaries fosters autonomy and independence in clients, whereas progressive boundary violations restrict their freedom to explore and choose.

The importance of maintaining adequate treatment boundaries becomes apparent when one considers the nature of the therapeutic process. A large body of research has consistently pointed to the quality of the therapeutic alliance as a critical factor in successful therapeutic outcome (Whiston & Sexton, 1993). Proper boundaries provide a foundation for this relationship by fostering a sense of safety and the belief that the clinician will always act in the client's best interest. This foundation permits the client to develop trust in the therapist and to openly express secret fears and desires without fearing negative consequences (Langs, 1982; Simon, 1992). Moreover, establishing clear boundaries about what is and is not acceptable within the therapeutic context sets a standard for unambiguous communication

between therapist and client and decreases the possibility for misinterpretations of the therapist's messages, motives, and behaviors (Langs, 1982). Given this definition of treatment boundaries, it is clear the boundaries are regularly transgressed by even the most competent therapists, and such transgressions are not always to the detriment of the client.

One may conceptualize the diversity of boundary transgressions on a continuum ranging from those that pose little, if any, risk of harm to the client to those that put the client at risk of indelible psychological injury and, in the most extreme instances, suicide (Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983). It is useful to distinguish between boundary crossing and boundary violation. Boundary crossing is a nonpejorative term that describes departures from commonly accepted clinical practice that may or may not benefit the client. The client who brings a Christmas gift to his or her therapist has crossed a therapeutic boundary by offering something over and above the agreed-upon fee for professional services. The therapist may decide to cross the same boundary and accept the gift. The therapist's decision, however, should be based not on a desire for the gift or on a desire to avoid the discussion that would ensue from refusing the gift but on a judgment of whether the client might be more harmed than helped by a refusal. The question the clinician must ask is, "How can my client most benefit? Can he or she tolerate and learn from my refusing this offering that violates the boundaries of our relationship?" Minor boundary crossings, especially those initiated by the client, can provide grist for the therapeutic mill and be an important focus of therapeutic work in psychodynamic

psychotherapies. A boundary violation, on the other hand, is a departure from accepted practice that places the client or the therapeutic process at serious risk (Gutheil & Gabbard, 1993; Simon, 1992). In the case of minor violations, it is often possible for the therapist to repair any damage by broaching the topic with the client and, if appropriate, apologizing to the client.

Although all competent clinicians would probably agree that setting appropriate boundaries is a clinical imperative, the wide range of theoretical orientations and techniques pose a major problem when attempting to delineate the proper boundaries of clinical practice. For example, a psychoanalytically oriented clinician may view a colleague's supportive brand of psychotherapy as indulging the patient's transference wishes and as clearly outside the acceptable limits of therapeutic practice. Consider the difference between the clinician who believes that effective psychotherapy can only occur within the four walls of the consulting room versus the therapist who accompanies patients (e. g., those with anxiety disorders) to various locales for in vivo exposure sessions. The issue of divergent belief systems among therapists is more than just a point of theoretical interest in this debate; it has serious real-life ramifications.

There are anecdotal reports in the literature of therapists who felt exploited by their clients (Gutheil & Gabbard, 1992). Several authors reported that patients with borderline personality disorder present a particular challenge in maintaining treatment boundaries because they are usually adept interpersonal manipulators and often attempt to draw the therapist out of the therapeutic role and into a " special" relationship (Gutheil, 1989; Simon, <https://assignbuster.com/boundaries-has-its-foundation-in-ethics-psychology-essay/>)

1989). In a more extreme statement, Slovenko (1991) asserted that the emotionally deprived therapist is often “ the innocent and vulnerable one, especially with patients who are young, attractive, and malicious” (p. 604). Unfortunately, the motives of some of these authors have been misconstrued in today’s rather volatile political climate, leading some critics to suggest that their accounts are veiled attempts to “ blame the victim” (see Gutheil & Gabbard, 1992).

Among the many types of boundary crossings, dual relationships (e. g., in which a client is also a friend or colleague) present a particularly difficult challenge. Dual relationships include situations in which a psychologist functions in a professional role concurrently or consecutively with another “ definitive and intended role,” professional or otherwise (Sonne, 1994). This definition excludes inconsequential roles that arise from chance encounters. Generally, professional organizations prohibit dual relationships because of the risk of harm posed by incompatible behaviors that might arise from the multiple roles (Gottlieb, 1993).

Like the issue of dual relationships, the issue of physical contact (exclusive of overtly sexual contact) with clients in therapy is not easily resolved. On one side, a gentle, reassuring touch or hug can be the most appropriate response at certain times or with certain clients (Holub & Lee, 1990; Simon, 1992). On the other hand, clinicians practicing such behavior run the risk of having it interpreted as a sexual advance, leading to undesired consequences for both the clinician and the client (see Gutheil, 1989, pp. 600-601, for a description of such a case). There are also cultural factors to be considered.

The issue of therapist self-disclosure has received considerable attention in the literature. Freud espoused a rigid view on therapist self-disclosure, instructing the analyst to remain “opaque to his patients, like a mirror and show them nothing but what is shown to him” (as cited in Lane & Hull, 1990, p. 33), an instruction that he frequently contradicted in practice. Disagreeing with Freud’s theory on the genesis of neurosis, Ferenczi experimented with several techniques designed to “unmask his own professional hypocrisy” through sincerity, authenticity, and truthfulness. In its most extreme form, Ferenczi’s technique included mutual analysis in which the regular analytic session was followed by a second session in which the patient analyzed him (Lane & Hull, 1990). Likely, this would not be considered acceptable practice by the current ethical standards.

In the context of the rising number of sexual misconduct cases, self-disclosure has become an ethical and legal concern to psychotherapists. Case analyses have shown that sexual intercourse with clients does not occur in isolation. Typically, there is a gradual erosion of treatment boundaries before sexual activity is initiated (Simon, 1989). Inappropriate therapist self-disclosure, more than any other kind of boundary violation, most frequently precedes therapist-client sex (Simon, 1991).

In certain circumstances, however, self-disclosure by the therapist can be a powerful intervention, and many contemporary schools of psychotherapy encourage its practice (see Stricker & Fisher, 1990, for a comprehensive review). The hallmark of appropriate self-disclosure is that it is done for the client’s benefit within the context of the therapeutic process. Used as a tool to instruct or illustrate, the therapist’s disclosure of some past event or

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problem can help the client overcome barriers to therapeutic progress (Dryden, 1990; Lane & Hull, 1990). Informing the client about personal conditions that might cause interruptions, such as illness or pregnancy, may also be necessary (Lane & Hull, 1990; Simon, 1991). Disclosures by the clinician that are generally not considered suitable include details of current problems or stressors, personal fantasies or dreams, and social, sexual, or financial circumstances (Gutheil & Gabbard, 1993; Simon, 1991).

In a 2008 article written for the Journal of Clinical Psychology Pope tells us that there are 9 activities we should perform when considering whether a specific boundary crossing is likely to be helpful or harmful, supportive the client and the therapy or disruptive, and in using due care when crossing boundaries.

We must first consider the best case and worse case outcomes of the action. Is there risk of negative consequences? Do these risks outweigh the benefits? If damage is done through this action can we fix it. Basically we are doing a cost benefit analysis of the interaction and using that for the basis of continuing or ceasing said action.

Secondly we should consult the available literature concerning the topic thus making ourselves aware of how many things affect our ability to understand the effects of our potential actions on the clients we serve. Theoretical orientation, gender of client and self and cultural issues are a few of the things that we must consider.

Equally of importance is having a firm grasp on professional guidelines, ethics codes, legislation, and we should familiarize ourselves with case law that has originated from situations similar to the one we are facing .

All clinicians should have at least one colleague with whom they feel comfortable enough with to discuss with complete openness and honesty boundary crossing they are considering. It is easier to know the way out of the woods if someone outside shares their perspective on how to get out. Or to put it another way it is hard to see the forest through the trees.

There are a plethora of things that can affect our ability to accurately assess the results of our actions on our client. If in our initial consideration of the situation results in any feelings of uneasiness, or doubt about the effectiveness we should be sure not to allow our fatigue, stress, being in a hurry, not wanting to disappoint a client who wanted to cross that boundary, or failing to appreciate the potential that boundary crossings have to affect clients and the therapy.

The relationship we develop with our clients and the subsequent progress we help them achieve should always be paramount in our decision making process. From the very start of the therapeutic relationship with a client we should express in plain and simple language how we as a clinician operate. This serves a couple of purposes as it meets a portion of the required informed consent and also allows the client the opportunity to assess if this clinical approach seems like a method that will allow them accomplish what they are hoping to accomplish. If this proves to be untrue it is advisable that a referral to another clinician be offered, as building off a foundation that is

tainted with doubt or uneasiness will not result in the most effective treatment and subsequent growth for the client.

Additionally this initial interaction allows the clinician to gauge their own comfort and belief in the ability to develop the therapeutic relationship to its fullest benefit for the client. Issues such as lack of familiarity with the issues the client presents or even personal attributes of the client that cause the clinician to feel uncomfortable enough that it will make it difficult at best for them to work effectively with the client.

We must also be sure to fully disclose the boundary violation we are considering with the client and ensure that they understand the ramifications to the best of their ability before proceeding. This allows for the client to be able to understand where we are coming from and where we are trying to get to.

Finally once the decision has been made that the best course of action for the client is that a boundary will be crossed we should be sure to have clear and extensive documentation describing exactly why, in your clinical judgment, this was (or will be) the most beneficial thing for the client.

In conclusion sorting out boundaries and establishing which are flexible and which must remain firm is no small task for us as clinicians. Ultimately we must always fully consider the ramifications of all our actions and inactions when guiding our clients towards development of their best possible selves on a case by case basis. Although there are some boundaries that are simply non-negotiable such as having any kind of sexual relationship with a client there are many others such as a hug or touch for comfort. That is as long as <https://assignbuster.com/boundaries-has-its-foundation-in-ethics-psychology-essay/>

the intention is clearly stated and clearly understood by both parties. In every case the most important thing to consider is the best interest of the client. These situations should not be taken lightly. They have the potential to not only be destructive to the therapeutic relationship but also pose a threat of harming all parties involved if administered haphazardly.