How Certain Boundaries and Ethics Diminish Therapeutic Effectiveness

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When taken too far, certain well-intentioned ethical guidelines can become transformed into artificial boundaries that serve as destructive prohibitions and thereby undermine clinical effectiveness. Rigid roles and strict codified rules of conduct between therapist and client can obstruct a clinician’s artistry. Those anxious conformists who go entirely by the book, and who live in constant fear of malpractice suits, are unlikely to prove significantly helpful to a broad array of clients. It is my contention that one of the worst professional/ethical violations is to permit current risk-management principles to take precedence over humane interventions.

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Civilized interactions depend heavily on recognizing and respecting boundaries. To violate a boundary, whether of an entire nation or one individual, is to usurp someone’s legitimate territory and invade his or her privacy by disregarding tacit or explicit limits. In quality relationships, people honor one another’s rights and sensibilities and are careful not to intrude into the other’s psychological space. It is therefore not surprising that the literature on psychotherapy continues to dwell on this important issue from many different perspectives.

Ethical considerations are closely related to matters of personal and interpersonal boundaries. The recently revised ethical principles of psychologists (American Psychologist, 1992, Vol. 47, no. 12) spells out numerous specific boundaries that all professional psychologists are required to respect. Many of the ethical principles and proscriptions emphasize the avoidance of harassment, exploitation, harm, and discrimination and underscore the significance of respect, integrity, confidentiality, and informed consent. Nevertheless, when

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taken too far, these well-intentioned guidelines can backfire. Furthermore, some psychotherapists have constructed artificial boundaries and tend to embrace prohibitions that often undermine their clinical effectiveness.

During my internship in the 1950s I was severely reprimanded by one of my supervisors for allegedly stepping out of role (one type of boundary) and thereby potentially undermining my clinical effectiveness. In many quarters, clearly demarcated client-therapist roles have been very strongly emphasized in recent years. It had come to my supervisor's attention that at the end of a session I had asked a client to do me the favor of dropping me off at a service station on his way home. My car was being repaired, and I had ascertained that the client would be heading home after the session and that I would not be taking him out of his way. My supervisor contended that therapy had to be a one-way street and that clients should not be called upon to provide anything other than the agreed-upon fees for service. Given my transgression, my supervisor claimed that I had jeopardized the client-therapist relationship. Interestingly, I recall that my rapport with the client in question was enhanced rather than damaged by our informal chat on the way to the service station.

The extent to which some clinicians espouse what I regard as dehumanizing boundaries is exemplified by the following incident. During a recent couples therapy session, the husband mentioned that he had undergone a biopsy for a suspected malignancy and would have the result later that week. Our next appointment was 2 weeks away, so I called their home after a few days to ask about the laboratory findings. The husband answered the telephone, reported that all was well, and expressed gratitude at my interest and concern. The wife, a licensed clinical psychologist, had a different reaction. She told a mutual colleague (the person who had referred the couple to me) that she was rather dismayed and put out at what I had done, referring to it as the violation of a professional boundary. A simple act of human decency and concern had been transformed into a clinical assault.

A different boundary issue was raised in the columns of a state journal. A therapist was treating an adolescent and wanted to arrange a meeting with the boy's mother. A busy professional, the mother's schedule was such that the most convenient time was during a lunch break, and she suggested they meet to discuss the matter at a local restaurant. The position taken by various correspondents was that this would not only transgress various boundaries but constitute a dual relationship. I wondered whether meeting in the park, or at the mother's place of work, in a hotel lobby, or in a car would be similarly discounted. Or could the venue indeed be a restaurant if no food but only coffee were ordered?

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1It has been argued that meetings outside the office, followed by sessions during lunch, often lead to dinner dates, movies, and other social events, finally culminating in sexual intercourse (see Gabbard, 1989, Simon, 1989)
During more than 3 decades of clinical practice, I have emphasized the need for flexibility and have stressed the clinical significance of individual differences. Dryden (1991), in an interview with me that he aptly subtitled “It Depends,” clearly accentuated my contention that blanket rules for one and all will often bypass important individual nuances that have to be addressed. With some clients, anything other than a formal and clearly delimited doctor–patient relationship is inadvisable and is likely to prove counterproductive. With others, an open give-and-take, a sense of camaraderie, and a willingness to step outside the bounds of a sanctioned healer will enhance treatment outcomes. Thus I have partied and socialized with some clients, played tennis with others, taken long walks with some, graciously accepted small gifts, and given presents (usually books) to a fair number. At times, I have learned more at different sides of a tennis net or across a dining room table than might ever have come to light in my consulting room. (Regrettably, from the viewpoint of present-day risk management, in the face of allegations of sexual impropriety, it has been pointed out that such boundary crossings, no matter how innocent, will ipso facto be construed as evidence of sexual misconduct by judges, juries, ethics committees, and state licensing boards.)

Out of the many clients that I have treated, the number with whom I have stepped outside the formal confines of the consulting room is not in the hundreds, but give or take a few dozen. And when I have done so, my motives were not based on capriciousness but arose from reasoned judgments that the treatment objectives would be enhanced. Nevertheless, it is usually inadvisable to disregard strict boundary limits in the presence of severe psychopathology, involving passive–aggressive, histrionic, or manipulative behaviors, borderline personality features; or manifestations of suspiciousness and undue hostility.

Some years back, I was treating a “difficult” patient who was combative and contentious. He arrived early for his appointment one morning while I was still having breakfast. An intuitive whim led me to invite him to pull up a chair and have some toast and tea. This was a turning point. The act of “breaking bread” resulted in a cooperative liaison in place of his former hostility. Let me not be misunderstood. I am not advocating or arguing for a transparent, pliant, casual, or informal therapeutic relationship with everyone. Rather, I am asserting that those therapists who always go by the book and apply predetermined and fixed rules of conduct (specific dos and don’ts) across the board will offend or at the very least fail to help people who might otherwise have benefited from their ministrations.

For example, a psychiatric resident was treating a young woman who often asked him personal questions. “How old are you?” “Where did you go to

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2 Except for a period of 5 years when I worked out of a professional office, my private practice has been conducted out of my home. This, for many, is in and of itself a transgression of a significant boundary.
school?" "Do you enjoy the ballet?" "Are you married?" In keeping with his supervisor's counsel, he studiously sidestepped all of these questions and asked about their intent. But the therapy was going nowhere, and he joined one of my supervision groups "I think the patient is about to drop out of therapy," he said. This matter was discussed at length, whereupon I advised him to apologize to his patient, to explain that he meant no disrespect but was merely following his previous supervisor's advice. I recommended that he answer each of her questions, even showing her the photo of his young son that he carried in his wallet. At the next supervisory meeting, he reported having carried out his assignment and stated that their therapeutic alliance seemed to have been greatly enhanced, for the first time ever, real gains had accrued. The patient continued making progress.

There is something demeaning and hostile about having one's questions dismissed and answered by another question.

Client: "Have you seen the latest Tom Cruise movie?"
Therapist: "Why is this important?"
Client: "Is your car the blue Chevy with the white interior?"
Therapist: "Why do you want to know?"

It is even more demeaning when therapists simply dismiss straightforward queries.

Client: "Did you play hockey in high school?"
Therapist: "We are here to discuss you, not me."

Unless there are valid reasons for not being forthright, or unless the question goes beyond the bounds of propriety, why not answer it candidly and then inquire as to its significance? "Yes, I was quite an avid hockey player in high school. Why do you ask?"

An example of what scares me as an excessive boundary issue was related by one of my students. He was seeing a client who had written a short poem that she wished to share with him. According to my student, his supervisor was concerned that he may have taken the poem and read it, rather than having asked the client to read it to him. The supervisor had allegedly stated, "It's best not to touch or handle clients' personal possessions." This type of rigid professionalism is most unfortunate and seems likely to breed alienation and distance and is apt to rupture the therapeutic relationship rather than foster it.

My thesis is that it doesn't hurt to temper rules and regulations with a touch of common sense. Thus a colleague referred a couple to me. After two sessions, it seemed that their individual agendas took priority over their dyadic transactions, and I suggested to my colleague that she might want to work with the wife while I treated the husband. A few weeks later, I asked my colleague if she
felt, as I did, that the marriage was probably bankrupt. "I can't discuss this with you because I have not obtained [the wife's] permission to do so," she replied. Ethically, my colleague was certainly toeing the line, but to my way of thinking, she exercised poor clinical judgment. My question was not an idle, voyeuristic attempt to pry into her client's privacy. It was geared toward a potentially helpful collegial exchange of information. Besides, having seen the wife myself, I was not a casual outsider, but someone who was concerned about and involved with the dyadic system.

By contrast, I was approached by a colleague who was treating one of my former clients and wanted specific information about him. Strictly speaking, I should first have obtained a written release from the client. Instead of wasting time, I simply told my colleague about traps and barriers that the client had erected that had undermined the therapy. I was able to alert her to various pitfalls that the client was likely to dig into which she (like I) would probably fall unless she exercised due caution. She subsequently informed me that my caveats were of enormous clinical value in forestalling a self-sabotaging client from destroying his life. My motives behind this collegial interchange were obviously entirely in the client's best interests.

I have crossed many boundaries to good effect. I have even treated relatives and friends in addition to colleagues and acquaintances, and some of my closest friends are former clients. Nevertheless, my plea for flexibility and my defence of unorthodoxy are not completely heretical. I remain totally opposed to any form of disparagement, exploitation, abuse, or harassment, and I am against any form of sexual contact with clients. But outside of these confines, I feel that most other limits and proscriptions are negotiable. But the litigious climate in which we live has made me more cautious in recent years. I would not take certain risks that I gave no thought to in the 1960s. For example, I accepted two clients into my home (at different times). One lived with my family for several weeks, the other for several days. Both were men from out of state who had relocated and were looking for a place to live. Similarly, I would have thought nothing of offering a client our spare bedroom on a snowy night or furnishing a couple of aspirins if someone asked for them. But like most of my colleagues, I have attended seminars on how to avoid malpractice suits that have made my blood run cold. It is difficult to come away from those lectures without viewing every client as a potential adversary or litigant. Fortunately, the effects tend to wear off after a few days, and I regained my spontaneity. But the ominous undertones remain firmly implanted and are reinforced by passages in books that explain how innocent psychologists can protect themselves against unwarranted lawsuits (Keith-Spiegel & Koocher, 1985). Consequently, being more guarded has rendered me a less humane practitioner today than I used to be in the 1960s and 1970s.

It is interesting that Freud gave some patients gifts, loaned them books, sent them postcards, offered a meal to the Rat Man, and even provided financial
support in a few cases. Perhaps Freud's most striking boundary violation was the analysis of his own daughter, Anna. According to Gutheil and Gabbard (1993), "these behaviors are no longer acceptable practice regardless of their place in the history of our field" (p. 189).

While reading a book on psychodrama by Kellermann (1992), I was particularly impressed with his account of a client who had participated in psychodrama groups for many years. When asked what she had found most helpful, the client stated,

"The most important thing for me was that I established a close relationship with Zerka," a kind of friendship which extended beyond the ordinary patient-therapist relation. She took me to restaurants and on trips and treated me like my own mother had never done. That friendship had such a great impact on me that I can feel its effects to this very day! (p. 133)

It is, of course, safer and easier to go by the book, to adhere to an inflexible set of rules, than to think for oneself. But practitioners who hide behind rigid boundaries, whose sense of ethics is uncompromising, will, in my opinion, fail to really help many of the clients who are unfortunate enough to consult them. The truly great therapists I have met were not frightened conformists but courageous and enterprising helpers, willing to take calculated risks. If I am to summarize my position in one sentence, I would say that one of the worst professional or ethical violations is that of permitting current risk-management principles to take precedence over humane interventions. By all means drive defensively, but try to practice psychotherapy responsibly—with compassion, benevolence, sensitivity, and caring.

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