Boundary Issues and Violations

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What would a forensics column be without an occasional discussion of boundary issues? Incidentally, do you know that your malpractice insurance probably doesn't cover most of what follows? Think about it.

SEXUAL BOUNDARY VIOLATIONS

All major professional organizations decry sexual activity with patients. Many also include past patients. Several states have laws making such behaviors specific causes of action for lawsuits, or even crimes. The prohibitions often seem clear, but may not define "sexual activity" very well. In addition, statutes and ethical guidelines may not differentiate 1) brief behaviors from lasting, calculated, and/or predatory ones; 2) recent behavior from that which occurred decades ago; or 3) intense therapeutic relationships from one-time consultations. Nevertheless, rigid requirements and interpretations are facts of life. Clinicians should be highly aware of the rules in their profession and locale, and how their behavior may appear to a sometimes accusing or suspicious public.

An older clinician with an excellent reputation had a brief affair with a patient early in his career. He quickly felt remorse and took all the professional steps believed appropriate by his profession at the time of the transgression (e.g., took responsibility for his behavior, terminated the affair, stopped treating her, referred her to another therapist, and entered psychotherapy himself). There was no indication of sexual activity with other patients for the remainder of his career. Many decades later, the former patient threatened to make the affair public if he did not pay her a large sum of money. He contacted the police and informed his state licensing board and professional organization.*

The licensing board investigated and declined to take any action, citing the years that had passed, the actions he had taken to minimize damage to this and future patients, and his current reputation. His professional organization, however, expelled him in spite of numerous recommendations for less punitive action.

*The possibility of extortion is yet another reason, albeit not the primary moral or ethical one, to avoid sexual behavior with patients.

"Consent"

In most circumstances, consent by an adult, competent patient is not a defense (or not a very good one) against allegations of sexual impropriety. Various theories question patients' capacity or opportunity to give adequate consent to sex with clinicians, including the fiduciary trust between clinician and patient, exploitation of transference feelings, the right of the patient to expect *clinical* needs to be the overriding priority, exploitation of the patient's purported inability to resist the therapist's influence, and an alleged "power differential" between *any* patient and his or her clinician.

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We are entrusted with extremely intimate information, and with the responsibility for helping patients correct their problems, not adding to them. Every patient who shares his or her feelings and experiences with us, or who might do so in the future, deserves to be able to rely on both our moral and professional competence. Our ethical promise must stand the test of intimate relationships, in private, over long periods. We are susceptible to our own internal foibles, conscious and unconscious, which, if not controlled, can quickly place the patient in jeopardy.

Clinicians sometimes ask about doctors or therapists who have married a patient. Laudable or not, I know of

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no case in which a clinician has been sued or prosecuted simply for marrying a patient who was unmarried during treatment. Breaking up a patient's marriage is another matter.

A clinician left his wife for a current, married patient, whom he eventually married. The former patient's ex-husband filed charges of "criminal conversation" (based on a state law against one person's sabotaging the marriage of another), and the clinician eventually lost his license.

It seems reasonable to assume that a prior clinical relationship would be a serious problem in divorce proceedings, but I have no data on the subject. It is clear, however, that nonmarital relationships with former patients have a substantial chance of ending in lawsuits or accusations of unethical behavior.

Avoiding Opportunity for Accusation

Counselors and therapists often decry their vulnerability to criticism for touching patients in any friendly or therapeutic way.[1] Risk managers may warn against even touching a grieving patient's shoulder, saying it could lead to undue familiarity. I disagree, and believe that common sense, with adequate documentation, usually allows appropriate expression of sympathy and empathy without much fear of criticism. Be aware, however, that minor boundary violations (e.g., loaning bus fare or failing to discuss the therapeutic implications of a small Christmas gift) sometimes evolve later into major ones. Investigations of severe violations regularly reveal an earlier, escalating series of less serious ones.

"Red Flags" in Ethics Actions or Lawsuit Petitions

Paranoia aside, some actions have the *appearance* of being unwise. Coincidentally or not, the following frequently appear in lawsuits involving sexual allegations. Note that the use of feminine pronouns does not alter the fact that at least 10% of improper sexual behavior occurs between female therapists and male patients or between therapists and patients of the same sex.

- Failing to document incidents or parts of the treatment that reasonable therapists would be expected to note in the record (e.g., gifts, telephone calls, or sexual material and clinical discussion about it). It is difficult to convince others that something is routine if it appears to have been hidden.
- Seeing patients of the opposite sex alone in a deserted clinic or office, especially during odd or evening hours.
- Changing session hours or circumstances to such a setting without documenting the reason.
- Seeing patients alone in their homes or yours.
- Avoiding supervision, consultation, or documentation with one or two female patients when such activities are routine for other patients.
- Locking the office door during therapy sessions.

Less Often Criticized, But Sometimes Cited

- Non-routine calling of a patient by her first name and/or vice versa without considering its therapeutic implications.
- Engaging in particularly frequent, intensive, and/or private therapy not usually associated with one's professional training or clinical style.
- Telling office staff in some unusually vigorous way not to disturb sessions, such as berating them for knocking on the office door.
- Having suggestive artwork or materials visible to patients.*
- Being known as a clinician who focuses on sexual problems.
- Talking a lot about sexual topics that are not related to the patient's primary complaint.
- Being a male therapist with a large caseload of women with relationship problems.

Many (not all) of the above are usually innocent. Some may be clinically indicated, routine, or merely a matter of the therapist's style. Nevertheless, clinicians should be alert to the possibility of their own rationalization and denial when they treat some patients as "special," and be aware that their behaviors may at some point be questioned by lawyers and juries.

Taping Therapy Sessions

Taping therapy sessions solely to defend against accusations has never seemed to be a good idea to me. There are settings in which it may be indicated, but, in general, to record for such an obviously defensive reason adds a nontherapeutic dimension to an activity that should be focused on clinical issues, not the potential for future accusation. It makes a bit more sense to record trainee sessions, or those of clinicians who require some form of probation or supervision. Recording creates documentation, and some may feel it is an extra "conscience," but practitioners who choose to record their sessions may be those least likely to transgress.

If you do record sessions, be certain that the patient agrees to both the recording and the method of storing the tapes. Audibly document the date and time of each session. Storing tapes in the office is one option. For additional security and credibility, one can use a service that will set up automatic, tamper-resistant equipment and store the audio or videotapes, which are warranted

*There is, of course, no reliable definition for "suggestive."

unaltered and confidential until unsealed by an appropriate authority.

Office Hours, Locations, Oversight

Experienced therapists know that the easiest hours to fill are often early, late, lunch hour, or on Saturdays. Those times are convenient for patients who work, and are logical "moonlighting" hours for clinicians with salaried jobs. Professionals with part-time practices are more likely than others to use home offices or other places that lack support staff. While there is nothing inherently wrong with this, such locations, like irregular hours, lend themselves to doubts if one is accused of improper behavior.

Having said that there is nothing wrong with unusual hours or locations *per se*, it is important to add that the *reasons* for them can either support or refute an allegation of impropriety. For example, why would one suddenly change regular mid-afternoon appointments to 6:00 PM, after the receptionist has gone home? Changes in time or setting generally raise more concerns than schedules that have been in place from the beginning.

> *A therapist was accused of an affair with a patient at a mental health center. The plaintiff raised the point that he had changed the site of her therapy from a central clinic to a more isolated rural one. The lawsuit alleged that he had begun to see her during lunch hours and in the late afternoon (although review of the appointment schedule suggested that this was not the case), often encouraging the lone receptionist to go to lunch or leave for the day while the patient was still there. The case was settled for an unknown amount.*

Sometimes the *patient* tries to create an environment in which the clinician-patient relationship becomes "special." Therapists may be consciously or unconsciously susceptible to such seductions,* which are more common with some diagnoses than others. One should be alert to patient (or clinician) impulses to seek out a potentially troublesome treatment circumstance.

Clinical organizations have a duty to be aware of potential problems among trainees and employees. The credentialing process deals with part of the duty, but there may be responsibility to monitor treatment environments and scheduling for some clinicians (particularly trainees or those on some form of probation). In my opinion, current standards of care and clinic management do not require monitoring of ordinary clinicians' scheduling and offices when there is no reason to suspect improper behavior.

**Seduction* is used here in its psychodynamic sense, and does not necessarily imply sexual behavior.

Responsibility for Reporting

Most state professional boards (particularly those which license psychologists and physicians) have some requirement that licensees report colleagues reasonably suspected of sexual activity with patients. The mandate may be part of rules about reporting clinicians who are not practicing safely and competently, or may be included in a specific rule regarding sexual behavior. Several states have strict reporting laws in addition to administrative rules. The most stringent require that if any patient mentions a sexual relationship with a former doctor or therapist to a *current* clinician, the current one must report it to the appropriate authority. In at least one state, such a report must be made regardless of whether or not the patient wishes to keep it private. Be certain you understand your state's reporting requirements for your profession, and follow them.

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NON-SEXUAL BOUNDARY VIOLATIONS

Trying to "Help" Patients Inappropriately

While it may sometimes appear to be in the patient's interest to give a diagnosis that qualifies him or her for reimbursement, hospitalization, or disability payments, or even to testify falsely on a patient's behalf in a legal matter, it is unethical and illegal to do so. In addition, such behavior moves outside the clinician-patient relationship to become a "special favor," and communicates acceptance of dishonesty. In a worst-case scenario, the patient can turn the dishonesty or fraud into a tool for blackmailing the clinician.

When an insurance company or disability agency requests copies of your existing records, you should comply as long as the patient has authorized release of the information. It is prudent to tell the patient what information will be released and discuss the possible consequences. It is *not* appropriate to "collude" with the patient to create inaccurate or misleading information for the third party. If your patient is not currently receiving benefits but may deserve them, you may suggest that he or she consider applying so long as your intent is to help the patient, not to increase your own income. I

believe it is generally inappropriate for treating clinicians to perform primary disability assessments for their patients.

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Gifts

It may be unethical to accept substantial gifts or compensation outside one's routine fee or salary. Accepting a small gift may be harmless, but may also indicate (or portend) an inappropriate relationship or expectation by the patient. It is a therapeutic truism that patients do not give gifts without wanting something in return, and that the symbolism involved in the gift (whether or not it is accepted) should be discussed whenever there is a close therapeutic relationship.

Handmade gifts are often treated differently from purchased ones. It may be countertherapeutic to decline something the patient has produced himself, unless it is quite valuable. Discussion, documentation, and (if relevant) placing the gift in therapy-related context are all keys to dealing with the potential boundary issues. Incidentally, I suggest that one not destroy such gifts; it may be a good idea to file them with the patient's record when feasible.

When gifts are used as evidence of financial impropriety or undue influence, courts often consider whether or not the clinician benefitted directly. Donations to the therapist's favorite charity are different from becoming a beneficiary of a changed will or accepting a new Mercedes. Still, ethics charges may be brought in some cases.

An elderly patient told his psychoanalyst that he planned to leave him a substantial bequest. The clinician recommended against the action, and encouraged extensive exploration of the patient's wish and underlying motivation. When the patient died several years later, his will provided a large sum for a nonprofit organization of which the analyst was an officer. The analyst had not been aware of the change in the former patient's will, the bequest did not benefit him directly, and after some consideration, he recommended that the institution accept the money.

The former patient's children alleged that the analyst had unduly influenced their father and sued to recover the money. The institution settled the suit, but the analyst was charged by his professional association with violating ethical canons and was eventually expelled.

"Inside Information"

A corollary of "undue influence" is the situation in which one attempts to benefit from profitable "inside information," since that could constitute a substantial windfall and/or affect the treatment. Even if one overhears the information coincidentally, acting to benefit oneself may be unethical. For example, if a patient who is a company executive divulges some business matter during treatment which might affect the price of a stock, buying or selling the stock could be considered a breach of privilege, an action in other than the patient's interest, or insider trading.

The same applies to "tips" you might give to the patient. Your usefulness to patients lies in your clinical skills and the separation of your professional role from other roles which would be better filled elsewhere in their lives. Do not suggest, recommend, or even inform the patient about such things as investments, and be cautious about giving direct advice on such topics as employment and relationships. There is a difference between eliciting thoughts and feelings to encourage good decision making, and inappropriately influencing those decisions. (This does not imply that the clinician should not discourage a patient's destructive, illegal, or clearly immoral behavior, however, since that would rarely be in his or her interest.)

Reference

1. The 1997–1998 National Survey on Forensic Issues in the Mental Health Professions. In Reid WH: A clinician's guide to legal issues in psychotherapy. Phoenix, AZ: Zeig, Tucker & Co.; 1999.