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ON CONSIDERING DUAL RELATIONSHIPS

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In a national survey conducted by the American Psychological Association, published in 1992, after confidentiality, the issue of dual, blurred or conflictual relationships was the second most frequently described topic of ethically troubling incidents. Seventeen percent of the respondents reported difficulties maintaining clear, reasonable and therapeutic boundaries around the professional relationship with a patient. These difficulties were broad ranged. They included questions about serving as both therapist and supervisor to the same person. They raised the difficulty of being able to define what constitutes a dual relationship or conflict of interest in the first place.

From this survey as well as from other sources, what seems abundantly clear is the need for ethical principles to define dual relationships more carefully and to note with clarity if and when, and under what circumstances, they are ever therapeutically indicated or acceptable. Research and the professional literature that focuses on non-sexual dual relations underscore the importance and the implications of decisions to enter into or to refrain from such activities. While it is impossible to anticipate every pattern of multiple relationships or accidental or incidental extra-therapeutic contacts, there is a strong need for formal principles that will provide clear, useful and practical guidance as an aid to professional judgement.

It is clearly not in the scope of this paper nor the authority of its author to set down such principles and guidelines, needed as they may be. I will rather limit myself to certain of the dynamic factors that arise where boundary crossings become boundary violations with ethical and psychological ramifications. Often it takes considerable time for harmful consequences to be felt, acknowledged and understood as such. And often, regretfully, for one reason or another, they may not be rectifiable.

All conscientious therapists are familiar with the continual struggle to maintain the treatment boundary and to withstand the pulls that come from various sources to use patients for our own advantage. The issue of dual relationships rests on this more basic concern of boundaries, particularly when boundary crossings become boundary violations. Heightened awareness of these issues has come about as a result of an increase in sexual

misconduct cases, ethics committee hearings in various organizations and complaints to different licensing boards across the United States.

In a recent article published in the American Journal of Psychiatry, Thomas Gutheil, M.D. and Glen Gabbard M.D. examined the concepts of boundaries and boundary violations under several headings. Their presentation merits attention since it offers concepts and guidelines helpful in exploring and managing the vicissitudes of dual relationships.

The authors begin by offering three principles that govern the relationship among boundaries, boundary crossings, boundary violations and sexual misconduct. The first principle offered is that sexual misconduct usually begins with relatively minor boundary violations, a sort of slippery slope from one minor transition to another. Secondly, they point out that not all boundary crossings or even boundary violations lead to or represent evidence of social misconduct. Thirdly, they state that fact finders (civil or criminal juries, judges, ethics committees of professional organizations etc.) often believe that the presence of boundary violations, or even crossings that may be dictated by therapeutic needs, is presumptive evidence of or corroborates allegations of sexual misconduct. The authors note that recent court decisions show a trend towards findings of liability for boundary violations even where there has been no sexual contact.

Having stated these principles, Gutheil and Gabbard elucidate this theme by using headlines that are familiar to every clinician who must constantly decide about complex clinical matters. Some of those headings discussed are role, time, money, clothing, self-disclosure, language and physical contact.

Role: To help define a therapist's role, the authors suggest the question "Is this what a therapist does?". Obviously, the answer is subject to ideological variations depending on the mode of treatment used. None the less, it may provide a useful orienting device to avoid pitfalls of role violations. They point to the fact that most patients entering into treatment come with the wish, conscious or unconscious, that their therapist will be the ideal parent who, unlike their real parents, will gratify all their childhood longings. The therapeutic setting itself encourages transference to develop in such a way that these very wishes are rekindled. They suggest a distinction between "libidinal demands" (which cannot be met without ethical violations) and "growth needs" (which, if not met to some extent, inhibit growth). Every patient has the right to be empathetically understood. By going too far, however, in the direction of trying to provide parental functions that had been frustrated in their past, the therapist may create a dangerous situation wherein the patient may experience the therapist as making false promises. If the therapist can provide the patient with a car lift,

or books or a meal, as Freud did with the Rat Man, then why not take this as an implicit promise that the therapist will take responsibility elsewhere in the patient's life? How the therapist may intend his/her gesture is not equivalent to how the patient experiences it.

Time: Time defines the limits of the session itself. It provides structure and containment. Every clinician has had the experience with patients who derive reassurance from this as they deal with painful aspects of their lives-during the set time of the session only. Starting or stopping early or late are boundary crossings that may be subtle or stark. In some cases, phone calls between sessions, seen by some therapists as restructuring contact or soothing anxiety, may be seen as unnecessary by others, depending on how one views treatment on the expressive-supportive continuum Obviously, individual cases require individual choices.

Money: Gultheil and Gabbard see money as a boundary in the sense of defining the business nature of the therapeutic relationship. This is not love, they point out, it's work. Both parties may have difficulties dealing with this issue and they note that trouble begins precisely when the therapist stops thinking of therapy as his or her work. While there may be all sorts of reasons for seeing a patient at a considerably reduced fee, and to discuss this with the patient, letting a bill lapse or allowing a debt to mount, are seen as boundary crossings that can easily become violations.

The authors note that, to a fact finder, an unpaid bill suggests that the clinician is indifferent to making a living and raises the question of whether some other currency is being used. The authors state that experience shows that the usual problem underlying a patient's mounting debt is the therapist's conflict about money and all it dynamically means to each party. Bartering for services may blur the boundary between payment and gift and lead to considerable confusion within the patient.

Clothing: As bioenergetic therapists, this boundary is of particular relevance. Clothing is a social boundary. Yet, to facilitate body work, appropriate clothing for the patient is recommended. It is advisable that the patient be instructed to come to the session dressed suitably for the work. Tact and courtesy on the part of the therapist are essential in dealing with this issue and one which deserves considerable discussion at the beginning of treatment in order to be certain that the patient gives informed consent to these arrangements. As the treatment progresses, the therapist must be attuned to whatever fantasies arise within the patient surrounding this variance in the usual code of dress from most other social and therapeutic settings.

Language: it is important to note if, when, why and for whom there is a shift to the use of first names. While it may convey a greater sense of warmth and closeness, it may represent for some patients a false sense of

intimacy and social friendship. Care must be taken and attention paid to the meaning this has for each particular patient.

Self Disclosure: Again, each therapist must decide if and when and why to reveal anything of a personal nature to a patient. A therapist may acknowledge that a painful experience of the patient is familiar to him in order to foster the therapeutic alliance. When, however, a therapist indulges in self revelation, such as when the therapist speaks of personal fantasies, dreams, of social, sexual or financial details, of specific vacation plans of theirs, deaths in the family, self analysis as to one's motivation is in order. The patient is frequently burdened by such information and less able to set forth his own thoughts and fantasies. Such disclosures may also stir up feelings of envy and jealousy that can aggravate an already difficult task.

Physical Contact: In most psychotherapies and psychoanalysis, physical contact does not take place for all manner of reasons, including sound risk-management principles. In a body oriented therapy, as bioenergetic analysis, this boundary extends to limited physical contact which the patient expects and to which he or she gives informed consent. Under these circumstances, no boundary violation occurs. Physical contact is one of the things a bioenergetic therapist does. It is implied in his/her role. At another level, however, care must be taken lest physical contact be used to comfort a patient in such a way as to deprive the patient of the opportunity to deal with the resentment, anger and grief associated with the deprivations of childhood or of his current life. The therapist who hugs a patient may be trying to provide what was or is lacking by a parent, spouse or friend. The patient may feel entitled to more demonstrations of caring or fulfillment of all kinds of wishes. The hug may raise false hopes that when frustrated, could lead to intense rage that can undermine the therapy itself.

In all such boundary crossings, clinical judgement must be used to make decisions that require adequate discussion and exploration of therapist's motivations. The relationship between therapist and patient varies from one therapist to another and even between patients in the practice of the same therapist. Gutheil and Gabbard suggest that what may prove most useful in terms of risk management and therapeutic effectiveness is to carefully consider any departure from one's regular practice along with documentation for the departure. As good common sense would dictate, they also recommend consultation with respected colleagues.

Recommendations: Exploitative behavior is so hard to detect because it is often associated with self-deception. All studies undertaken have resulted in recommending time-honored methods that therapists have to avoid or address the issue of exploitation in their practices. Again and again one author after another urges ongoing supervision, continuing education, consultation with respected peers and of utmost importance, personal therapy. They also recommend open discussion of these issues as a reminder

of the perils involved in the course of our work as well as a preventative safeguard. Such a need exists despite the level of experience one has attained, since research has shown that extensive clinical experience may lead to overconfidence, rationalization and callousness in regard to boundary violations (Brodsky 1989).

Research results underline the need for training programs to include planning and evaluation of programs designed to increase sensitivity to dual relationships and boundary crossings and to ethical issues in general. Borys and Pope (1989) urge that such programs present literature in which the nature, causes and consequences of dual relationships are specifically explored. They suggest that the works read include those which advocate or defend the behavior in order to give students the opportunity to confront and evaluate the whole spectrum of arguments involved. They urge that the human dimension of dual relationships be brought into the forefront of the discussion, rather than the theoretical pros and cons. Experiences of those who have been involved in dual relationships must be explored rather than simply repeated. "If it was good enough for me, it's good enough for you" is a feeble yardstick indeed. Personal accounts, although difficult for a variety of reasons, kept the discussion grounded and less defensive and embattled.

One factor consistently appeared in all research done to date on dual relationships: there was a disproportionately large percentage of male professionals who approved of or engaged in a range of nonsexual and sexual dual relationships of the type prohibited by different institution 'and associations' codes of ethics. A disproportionately large proportion of female clients and students are the recipients of such unethical behaviors or boundary violations. Researchers urged that training programs address the causes of such systematic discrimination against women and explore why such behavior is allowed to continue.

There is a potentially useful tool for training and educational programs called "The Exploitation Index" created by Epstein and Simon (1989). This instrument is a self- assessment questionnaire for therapists designed to serve as an early warning indicator of boundary violations. It may be useful with individuals whose behavior and attitudes fall in the transitional category – explorative behavior that may interfere with the efficiency of treatment but that has not yet or may never become gross abuse.

Finally, everyone knows that in managing exploitative enticements, mistakes will inevitably be made. If these mistakes are detected, if they are even perceived as mistakes that impact upon the efficacy of the treatment in general, if they are properly understood, such errors can be of help in understanding the patient's problems and the nature of the therapist's own

countertransference. This can result in substantial therapeutic benefit and personal growth to both the therapist and client, provided the therapist is willing to recognize and emphatically acknowledge his mistake to the patient. (Virginia Wink Hilton, 1993).

Clinical Material

In an effort to help keep the issue grounded, the following clinical material is offered. It reveals more of the human dimension of dual relationships and the struggles and vicissitudes involved therein. The case chosen highlights dynamics found in several other cases as well.

The patient, D., is a married woman, in her late thirties with a young child. She came to treatment because of intense anxieties that accompanied wishes for an extra-marital affair. When in her early twenties, D. began working as a lay assistant/apprentice to a psychiatrist, Dr. L., who, sometime later, became her therapist as well. D. continued for several years in this dual relationship until Dr. L's unexpected death ended the contact. Like others in these circumstances, D. felt dr. L's dying as a catastrophe. This was no mutual emancipation following the achievement of therapeutic goals. (Firestein 1992). Rather, D. experienced Dr. L's death as a desertion and abandonment. Needless to say, such an ending has profound implications for the patient and her capacity for trust in subsequent treatment. For the purpose of this paper however, the focus will be upon the impact that the dual relationship had upon D's psychic life and functioning.

During the first few sessions, the single most striking feature about D. was just how very much alive for her Dr. L. still was. Although Dr. L's death had occurred over ten years earlier, D. spoke of him as if the death had been recent. In death, Dr. L. was idealized beyond the usual idealizations that every therapeutic relationship carries and which in the normal course of treatment is hopefully worked through. This, of course, did not occur here. D. remained loyal to her ideal, who was her therapist, teacher, friend and co-worker. It took at least a year of work together before D. could begin to relate to me as her therapist. By contrast I was a constant disappointment to her for so many reasons. In D's eyes, not only was I not as warm, compassionate, intelligent or witty as Dr. L., but even more significantly, I disappointed and angered her most because, unlike Dr. L., I did not offer her any hope of her being or becoming my co-worker or friend. It took many months of sustaining her angry attacks over this repeated frustration before we were able to begin to explore some of the impact on her of these multiple roles. She felt she truly "owed" Dr. L. It was Dr. L. who encouraged her to 'trust' herself by taking her in as his apprentice, when she had had no professional training. (Interestingly, it was not until after Dr. L's death that

D. pursued a degree in the mental health field. And it is equally noteworthy that D. had been and is employed in an entirely unrelated field.)

Dr. L. became the sole source of her learning in the field. D. watched him in the groups they co-led and longed to be able to intervene effectively as she felt Dr. L. did. She was grateful to her teacher for this opportunity for hands-on experience with a "pro". In her own therapy with Dr. L., D. made all sorts of allowances. For example, she took Dr.L's forgetting to appear for a morning session on the Sunday in Spring when daylight savings time went into effect as simple absentmindedness. D. "realized" that had happened, went to breakfast and came back an hour later when Dr. L. appeared for the session. When D. was able to admit to any feelings of anger or other negative feelings, it was always in a way that made it seem it was D's problem and pathology that was the sole source of the emotion, never anything in Dr. L's behavior or character. "How can you bite the hand that feeds you", she would think. D. had no credentials of her own and no source of income other than that which came to her as a result of her work with Dr. L. But her reliance upon her teacher/employer paled in comparison to the dependency she felt toward her therapist. "He was an ideal father figure for me," D. said. "He was the non-critical supportive, compassionate, understanding person my father was not and he believed in me." Yet, the dreams D. began to bring in showed another picture.

> I was in an orchard with other people. We were wandering through it and Came upon a watering hole about 6-8 feet deep. There were people swimming in it. I was concerned it was polluted because they washed the Machinery in it that they used for the orchard. The orchards were sprayed. We jumped in with our clothes on. I was worried about getting my wallet wet – the ink would run on my driver's license. I got out of the water. When I turned around, the swimming hole had suddenly dried up and disappeared into the earth.

As D. spoke of the dream, she saw it as a dream about her therapy with Dr. L. – a therapy that was polluted, one in which her own identity became blurred and was "wiped out." She understood the pollution ("cancerous") in therapy as coming from the admission of so many different feelings, wishes and conflicts that resulted from her multiple relationships with Dr. L. Slowly and painfully, she became aware of her rage, envy and rivalrous feelings toward Dr. L., of her intense sadistic feelings and of her guilt for having in fact been the 'winner' insofar as she had survived and Dr. L. was dead.

D. began to understand her passivity in the groups as serving several functions. It was a way to make Dr. L. look good – and all-powerful, fulfilling some of Dr. L's narcissistic needs, as well. In addition, D's 'shyness' was a drain on the group's functioning. These dynamics could not be explored in her treatment with Dr. L. since both benefited from the arrangement. D. felt 'special', chosen by Dr. L. as his assistant. She did not have to follow the rules that governed ordinary people who had to go the route of academic credentials. As in the Pygmalion fantasy, Dr. L. had the satisfaction of being the sole expert and role model for D. Gratitude was a heavy burden. D. owed Dr. L. so much. How could she be angry at someone upon whom she depended so entirely and who had treated her with such singular attention and favor? How could D. leave him, thereby admitting to both that Dr. L. was not enough? Only death was able to make this apparent.

D's early history contains the roots of her neediness and disposition to enter into and maintain such an arrangement with Dr. L. She was the eldest of three children, each born two years apart. Academically and socially, her two brothers have, as adults, excelled her. Unlike them, D. did not get an advanced degree until well into her thirties. Unlike them, she has never worked in the field in which she has been trained. To this day, D. has been unable to use to her benefit, except in a circumstantial way, the training she received from Dr. L. All the reasons for this are not clear, although D. does feel guilt at surviving Dr. L. D. does not feel she has the right to use, for her own advancement what she has worked to accomplish in this field. It might be said that on some level D. remains loyal at a pre-competitive, idealizing stage of the 'good father" (Dr. L.).

It is the pre-oedipal father which provides the early experience of being protected by the father and caringly loved by him, who becomes internalized as a life-long sense of safety in a "dangerous" world. It is to this pre-oedipal father, as well as to the pre-oedipal mother, that a sense of bodily integrity must be attributed more particularly for a boy but also in a real way for a girl (Blos, 1992). D. over idealized her therapist, reflecting the enduring influence of her pre-oedipal father and this father's role in D's first two years.

The resistance which is aroused in the present treatment whenever the work threatens to deprive D. of this father-illusion confirms the life sustaining influence which the early child-father relationship possesses in general, and in this case in particular. Certainly, this was something D. very much wished for, especially since D. felt abandoned by her mother when her brother was born two years after her own birth. D. must have clung even more closely to her father during those years as each sibling arrived.

Because Dr. L., in reality, protected D. and gratified many of her needs, he could not help D. resolve the regressive pull to the early father with which D. entered her first treatment. Dr. L. could not become the oedipal father for D. and therefore, D. could not work through her oedipal level conflicts. These conflicts could never enter the treatment in a dynamic energetic way and thus, neither could they be addressed nor worked through on a body level.

Among other consequences, Dr. L's death served to freeze this level of development in D. The continued effects of this are seen in D's marriage. D's relationship with her husband has a defensive quality, rather than a more mature love relationship in which its defensive nature would have dropped away if D. had developed beyond this pre-oedipal attachment. One may surmise that even if D. had been able to continue in treatment with Dr. L. such a resolution might never have taken place. There simply were too many boundary crossings, gratifications and reality based interactions that were part and parcel of their dual relationship to ever allow for a passage into a full blown oedipal conflict with hope for a successful waning.

As one might expect, D's body has an oral, dependent and passive appearance. Tall and thin, she appears underdeveloped, looking more like a girl than woman. Her eyes are often tense, and frightened. In the beginning, she rarely made eye contact. Habitually, she was at best ambivalent about being in therapy with me. The work had to progress very slowly to enable her to develop any feeling sense of her own body. As she grew to feel stronger and more grounded, she began to talk about her relationship with Dr. L. She needed to know that I would not take Dr. L. from her nor mar the image she had of him. She had to give him up rather than defend against being robbed of her ideal. While this seems fairly obvious and simple, it has been and is a painstaking process, one in which I am regularly criticized and found lacking. I was the frequent target of her rage and, while understanding the defensive purpose this served for D., it was not easy to bear. Over time, I have been able to convey to her that I thought I understood the important place Dr. L. held in her life, while also beginning to address the cost to her, D., in maintaining her loyalty. It is worth noting that as she trusted that I would not judge nor rob her, the tension in her small joints and around her eyes relaxed. Her breathing has deepened and her body is beginning to fill out.

As Freud said, no one gives up a love object willingly. There is a great deal of work that lies ahead. It is a painful process to see one's hero with feet of clay and to face the narcissistic injury of having been fooled by thinking and hoping it were otherwise. It is painful for D. to understand the exploitative features of Dr. L's decisions and actions. Diminishing time and

opportunities have begun to change the way D. viewed her multiple relationships with Dr. O. Developing her own strength, both physical and psychological, she now questions why she allowed someone to me so much to her while she continued to feel weak and small within herself.

The consequences upon someone of what seemed to be therapeutic effort are sometimes revealed only years later – if at all. This case demonstrates the complexity and cost for the patient of boundary crossings and violations. All of what Dr. L. did, one may assume, he did in an effort to be helpful. That is what makes it, on the one hand, so much more difficult for the patient to explore and, on the other, easy for the therapist to self-deceive. It underlines the necessity for all of us to be involved in an ongoing way in our own analysis and peer supervision.

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