Psychodynamic Perspective on Therapeutic Boundaries

Creative Clinical Possibilities

Nancy A. Bridges, L.I.C.S.W., B.C.D., C.G.P.

Discussion of boundaries in therapeutic work most often focuses on boundary maintenance, risk management factors, and boundary violations. The psychodynamic meaning and clinical management of boundaries in therapeutic relationships remains a neglected area of discourse. Clinical vignettes will illustrate a psychodynamic, developmental-relational perspective using boundary dilemmas to deepen and advance the therapeutic process. This article contributes to the dialogue about the process of making meaning and constructing therapeutically useful and creative boundaries that further the psychotherapeutic process.

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The psychodynamic formulation and clinical management of boundaries in therapeutic relationships remains a complex and controversial area of clinical practice. With professional sexual misconduct and nonsexual boundary violations remaining occupational hazards for psychotherapists of all disciplines, boundary maintenance issues have received increased attention in the psychiatric literature.[1–10] A psychodynamic perspective on how to make meaning and construct therapeutic boundaries in psychotherapy is more difficult to glean from the literature. Therapists are now well informed about the parameters of ethical conduct but confused about the ethical construction of creative, clinically useful boundaries in therapist-patient dyads.[11–15]

The conflict and controversy in the field are manifested in the heat generated by differing case formulations and the resulting technical interventions.[11–14,16–18] Some practitioners favor reliance on the traditional methods of protecting the treatment frame, avoiding even the appearance of boundary crossings and acknowledging the implicit authority of the therapist.[2,4,5,11] Other theorists favor an uncharted treatment approach of mutual discovery between therapist and patient.[15,19,20] This path allows for novel outcomes that may be enormously valuable but may not resemble

Received November 5, 1998; revised June 2, 1999; accepted June 2, 1999. From Cambridge Hospital, Harvard Medical School, and Smith College School for Social Work, Massachusetts. Address correspondence to Nancy A. Bridges, 135 School Street, Belmont, MA 02478.

conventional treatment boundaries. Passionately held contradictory positions espoused by senior clinicians make formulating psychodynamic boundary interventions a conceptual and clinical minefield for therapists.[12–14,16–18] Clinicians who deviate from traditional practice risk censure from those who consider they have entered a danger zone of boundary fluidity. Other theorists dismiss traditional interventions as exclusively limit-setting techniques that diminish mutuality and empathic dialogue.[19–22] An integrated approach, one that honors traditional parameters and yet encourages an openness to creative, uncharted outcomes within ethical frames, is hard to find.

This article offers an enriched view of the crucial boundary negotiations that illuminate patients' most painful transferential issues and what is achieved through careful, authentic exploration without a formulaic response by therapists. The case formulations borrow from a range of theories and offer one view of an integrated approach. The attitude and the clinical posture that the therapist assumes toward boundary dilemmas are clinically far more important than any particular boundary maintenance decision.[22–27] A psychodynamic perspective on boundary dilemmas focuses therapeutic exploration and promotes the use of these clinical issues to deepen the therapeutic conversation and advance the psychotherapeutic process. In the following pages, the vignettes are drawn from my own individual and consultative practice. For purposes of confidentiality, the vignettes are sufficiently disguised to be considered composites of situations that actually occurred.

BOUNDARIES AND THEORY OF THERAPEUTIC ACTION

The treatment boundary is a psychological containment field maintained by the therapist's mental capacity to encompass the patient's symptomatology and symbolic communications.[2,4,8] Treatment boundaries provide the built-in structure to contain and process communications.[2,4,5,8] Intrapsychic and interpersonal therapeutic boundaries need to be permeable, allowing for mutual influence, and yet offer containment and holding for intense affective experiences.[4,21–29] Effective therapeutic boundaries that are reasonably secure and permeable paradoxically protect and allow both therapist and patient to cross boundaries psychologically, with fantasies and feelings enriching therapeutic dialogue[4,11,20–34] (P. Russell, personal communication, 1983[35]).

Therapists' clinical choices and decisions about the understanding and management of boundaries are shaped by the theoretical perspectives they hold. I will offer an integrated dynamic, developmental perspective and will borrow from traditional and relational theories of therapeutic action. The central focus of these theories is on the larger relational system within which psychological phenomena crystallize and in which experience is continually and mutually shaped by both participants.[19–26,28–30,35]

Stolorow and colleagues[21] identify several important therapeutic concepts that organize and focus therapeutic understanding and work. The roles of affective attachment and attunement in the process of therapeutic change are crucial.[21–23,35] Other important therapeutic concepts and processes identified include an emphasis on the holding and containing functions of the therapeutic setting and relationship[19,26,27,35] and the need for patients to relive developmental dramas in the therapeutic relationship, including disruption and repair of selfobject injuries.[22–29,35] Additionally, the impact of the interpersonal, therapeutic experience to disconfirm transference expectations is crucial.[19–25,28,30–33,35] All of the writers I have cited on these topics emphasize the transforming, mutative power of new relational experiences with a therapist. The therapeutic, relational experience allows the individual to experience and develop new senses of self and to expand and deepen affective competence.

Psychodynamic, relational therapists have far greater freedom to decide what is therapeutic, and thus they face many more choices when confronted with therapeutic boundary dilemmas. As therapists, they value a greater mutuality and humanness in the treatment relationship.[19–22,25] Often, the therapeutic work is up-close in the transference-countertransference and the interpersonal therapeutic relationship.

GUIDELINES FOR FORMULATIONS

The therapist's task when confronted with clinical boundary dilemmas is to direct therapeutic inquiry toward an intrapsychic and interpersonal understanding of what is being communicated at this moment in the psychotherapy.

A dynamic, relational formulation will guide how

the therapist chooses to intervene. Boundary maintenance interventions are determined by one's clinical formulation and a careful assessment of how best to protect the patient's treatment. Each treatment dyad strives to construct meaning based on the distinctive influence of each participant and an understanding of what is being therapeutically negotiated. The clinical conversation about the meaning and construction of therapeutic boundaries in each treatment dyad is an important vehicle for deepening the therapeutic work and relationship.[22,23,29] Treatment boundaries will vary in flexibility and rigidity, depending on the therapist's formulation, the therapist's character, and how a particular patient engages the therapist's intrapsychic issues.[4]

The outer boundary for all treatment and treatment relationships is, of course, the fiduciary relationship and the code of ethical conduct as defined by each discipline. Within an ethical framework, each clinician must decide what treatment boundaries suit her or his personal and clinical style.

Patients may be harmed by clinical postures and interventions that are too distant from the relational context as well as ones that are too close to it.[36] The fiduciary relationship must never be abandoned regardless of the formulation. Sometimes when clinicians consider therapeutic intent of a particular intervention, they construct therapeutic boundaries that seem excessively close or out of place for a professional relationship. Consider the following clinical vignettes where therapists constructed creative boundaries that abandon the treatment frame or stretch it too far.

At the end of treatment, a family therapy team accepts a patient's offer to celebrate the end of a successful treatment with cake and a bottle of champagne.[15] Each team member toasts the mother with champagne and thanks her. The supervising therapist frames this intervention as empowering the mother and affirming her therapeutic gains.

This is a troubling clinical intervention. The use of alcohol with patients is ethically questionable and contraindicated. Consider the following vignette.

An analytic patient who went through a successful analysis at long last plans a marriage. The patient invites the analyst to the wedding but wishes her to attend accompanied by her significant other and to dance at the wedding. The analyst formulates the multiple requests from a relational perspective and chooses to honor all of her patient's requests.[37]

These interventions seem excessively close and outside the therapeutic frame.

Therapists must never keep clinical secrets about their practice. When formulating the psychodynamic meaning of boundaries and useful interventions, therapists must be comfortable revealing the details of the process, formulation, and intervention to a trusted peer or consultant. A wish to keep an intervention secret may signal a need for consultation or supervision. Ongoing consultations with a trusted colleague or senior clinician are vital to protect the process and the participants. Consultants who possess the courage and experience to respectfully question the therapist's approach are most valuable. Probing self-scrutiny is required for analysts to fully understand their own interest in and influence on the clinical process.[8,11,19–30]