CHAPTER 1

The ethical importance of boundaries to intimacy

Bobbie Farsides

Overview

Therapists occupy a privileged space in their clients' lives and have a relationship that falls between the public and the private domain in a challenging way. An ethical responsibility therefore exists for the individual therapist to ensure that his or her relationship with a client remains clearly wedded to its therapeutic purpose. This obligation must be recognised at the outset of the therapeutic encounter and will define the boundaries within which any work must be conducted. Even though the work to be done will entail an intimacy more common to private encounters, the relationship must be conducted with a propriety judged appropriate and fitting by professional peers. Setting boundaries is both a professional and an individual duty, the fulfilment of which protects both therapist and client.

Introduction

Sometimes you accept an invitation with a mixture of enthusiasm and trepidation, as was the case when I was approached to contribute to this volume. Just as you might relish a dinner party invitation when you know and like the other guests and feel that you have some interesting stories to tell, so as an academic I relish joining with others to explore a shared interest, particularly when my expertise is recognised and acknowledged. It is much more daunting to go to a dinner party when you know only the hostess, and the other guests come from her world rather than yours. Similarly, it is challenging to address the readers of this book, an expert audience, on a topic about which they have medical knowledge and expertise I do not share. As in the dinner party analogy, I can only hope to come up with some good stories to share, and a level of common understanding that will help the evening go well.

On this occasion, my perspective is that of an ethicist with a particular interest in the experience of healthcare professionals who operate in morally complex areas (Alderson *et al*, 2002; Ehrich *et al*, 2007). My work is also informed by my earlier academic career in which I studied and taught political philosophy, and by my personal experience as a woman growing up riding the second wave of British feminism. I have not experienced the type of therapeutic relationship upon which I will reflect, and ask for understanding of my necessarily lay perspective. It is for readers to judge what happens when they fill in the gaps with their own experiences, as therapist or client.

The therapeutic relationship

Relationships between consenting adults have generally been deemed a core component of our private lives. As such, in a liberal democratic society, they remain largely outside the reach of the state and its laws. Certain relationships become formalised and legitimised through the intervention of courts and registrars, but the way in which those relationships are subsequently conducted remains profoundly private. This means that, for some, the private realm is a safe space in which they can explore their individuality and develop their relationships with significant others. But for others, the private realm is a threatening or positively destructive environment in which their personal safety and well-being can be threatened. A constant challenge for those charged with the protection of others is to find a way to respect the private lives of others while at the same time ensuring that bad things are not happening behind closed doors.

The second-wave feminists, of the late 1960s and 1970s, who campaigned famously under the banner of 'the personal is political', understood this dilemma well (Nicholson, 1997). Their agenda was, in large part, driven by a concern for the invisibility of sexual discrimination, the abuse of women within the home, and the systematic exclusion of women from the public sphere. These feminists appealed to, rather than rejected, liberal doctrine by locating harms within the private sphere and then stating that they should nonetheless be the law's business. In taking this approach, they both challenged and absorbed the idea that the most justifiable reason for intervening in the private lives of citizens is the need to prevent harm to others. Where harms were universally experienced by women, and indirectly sanctioned by the state, the issue became political in the traditional sense of the term, despite the experience of those harms being seen as profoundly personal, situated in the home rather than in the public arena.

In terms of public and private, the relationship between therapist and client is an interesting hybrid. The client leaves his or her home and enters the therapist's professional space. This may be in a clearly designated public place such as a hospital or other institution, or may be an intimate

quasi-private space within the therapist's home. Wherever the space exists, it may give clues to the therapist's personal taste and interests, or it may be an utterly impersonal space, available as a work-space to others at different times.

In anything other than the most acute setting, one imagines that the ambience within the space will be carefully constructed in the interests of encouraging openness and trust, and much work will be done to make the client comfortable. The client brings problems to the therapist which may be more or less invisible to the outside world. The close and often intense one-to-one encounter that occurs in this space will be more reminiscent of encounters within the private spaces of the client's life than those experienced in public spaces. Conversations will be deep and revealing, confidences will be shared, and by assisting the client in dealing with problems the therapist will necessarily have to learn much more about the person who is their patient than, say, the orthopaedic surgeon or ophthalmologist.

It is possible, at least, that a closeness will develop that mimics and, in some senses, transcends that achieved with any of the client's significant others. Some of the information shared could be unpalatable for the therapist to hear, as difficult subjects will arise, but similarly the information revealed and examined could elicit feelings of empathy, admiration or attraction, which in other circumstances could be the type of response that would move a relationship on to another level.

It is therefore crucial for therapists to expertly construct the therapeutic relationship and manage the encounters that occur in the therapeutic space. One step towards this would be to ensure appropriate boundaries around their own feelings and responses, feeding them positively into the therapeutic project rather than allowing them to become part of a developing private relationship between two necessarily intimate individuals. This project needs to begin *long before* there is any question of impropriety as defined by law or professional guidance. A therapist in training must acknowledge the need to develop his or her skills in constructing and maintaining appropriate boundaries in relationships with clients. And those charged with training therapists must work to ensure that their students will be equipped with the skills required to do so.

It seems clear that a first step in constructing a healthy therapeutic relationship is an acknowledgement of the fact that the relationship is purpose-driven; thus, any feelings or actions played out within the relationship must serve that purpose. Similarly, the nature of the relationship must be fit for purpose. An interesting question then arises regarding whether, or to what extent, it might be appropriate to allow a potentially 'dangerous' intimacy to develop in the interest of achieving therapeutic goals. In a sense, the question being asked is whether boundaries are fixed and non-negotiable and recognisably the same across all cases, or whether there is room for experimentation in the interests of therapeutic advantage.

The need for professionalism

Clearly, the nature of this type of therapeutic relationship lends itself to a complex blurring of the private and the public, in terms of the space in which it occurs, the conversations shared and the potential responses and reactions of therapist and client. This being the case, there is the potential for relationships to head off in radically different directions if both parties simply allow themselves to go where the experience takes them. One way to manage the issue is to incorporate the notion of professionalism explicitly within the relationship and thereby ensure that one party is constrained in terms of what he or she can, and will, allow to happen.

A healthy professional–client relationship relies on the prior recognition of boundaries; hence the old adage of 'not mixing business and pleasure' arises, because the boundaries cannot be adequately set if a different type of relationship pre-exists the contractual exchange. A persistent trial of everyday life entails conducting relationships with those from whom one purchases services in a manner that demonstrates appropriate respect and concern, without losing the possibility of making appropriate demands or expressing dissatisfaction at the service provided. This problem of etiquette may not be present in the therapist–client relationship but other problems can arise. Part of the therapist's duty rests with acknowledging the possibility and preparing for it.

In the therapist–client relationship some boundaries are conventionally well recognised, such as the importance of regularity and timekeeping – the containment of encounters within specific time and space. Unlike the supportive friend or long-suffering spouse, the therapist allows the client into a designated space for a carefully negotiated amount of time. Therapists can therefore place clear limits on their availability in ways that those in the personal sphere cannot. Conversations can be interrupted and important issues carried over to a future session. This provides a useful reminder of the different nature of the therapeutic relationship, despite the fact that, during the time shared, it may seem very similar to relationships the client values and relies upon in private life.

The professional will have explicit duties of care to the client which are legally and professionally enforceable, such as the duty of confidentiality. This will be a comfort to the client, who may otherwise fear the seepage of information into the private domain. However, it is important to recognise that it is a *professional* as opposed to personal obligation which must be negotiated (as opposed to assumed). Experienced therapists will make it clear what can and cannot remain confidential, and as professionals they will have access to guidance and support on this issue. They will exercise a degree of discretion possibly uncommon among friends and family. They will (ideally) be far apart from their client's social circles, but will also be responsible for judging the danger attaching to truths shared, and they will at times have a clear responsibility to act upon information received.

The therapist will also work hard to retain the nature of the relationship as clearly and unambiguously therapeutic, in the face of any potential shifts in its nature. In some respects, this is part and parcel of the therapeutic process. For example, the therapist must recognise the possibility of transference; but it is also important that she or he recognises the possibility of less therapeutically explicable shifts, and constantly questions whether the relationship remains consistent with the therapeutic purpose.

In dry terms, being a professional entails membership of a professional group or body governed by shared standards of probity and (hopefully) good sense. Being a good professional also means that one should be open to the idea of self-regulation in the absence of clear guidance or explicit standards. In its richest sense, one's status as a professional is another interesting hybrid. Whatever your professional role you cannot lose your personal, private self completely, yet you must allow yourself to be supervised and potentially restricted from acting in ways which run counter to your professional duties. As a private individual you might experience this as challenging, unnecessary or maybe even damaging. Mindful professionals should be subject to an ongoing internal dialogue that helps to pull their personal self in line with their professional duties and role, but also allows their personal self to step away when that is not possible.

Building trust, negotiating relationships

In the public realm, professionalism is in large part about setting standards of good practice, disseminating them effectively to relevant parties and applying sanctions to those who do not meet those standards. Sometimes, however, the standards within a professional group slip or fail to adjust to broader societal shifts. The work of modern bioethics has been, in part, to shift modern medical culture towards a more explicit recognition of the need for sound ethical governance (Jonsen, 1993). There has been an explicit need to move on from the abuses of the past, such as enforced sterilisation of those with a mental impairment, retention of human body parts and conscription into medical research (see Chapter 4 regarding historical abuses).

Initially, bioethics borrowed heavily from the social contract theory of political philosophers. Doctors as professionals have similarly invoked the contractual model at a macro- and micro-level, with international medical associations signing charters and declarations, and individual doctors operating explicitly and implicitly within contracts of care which distribute rights and responsibilities between the healthcare professional and the client.

In recent times, bioethics discourse has also acknowledged the limitations of the legalistically characterised contractual model and has re-incorporated familiar concepts from traditional medical discourse, such as trust, the promotion of best interests and the idea of authorisation. This is not to rule

out the possibility or importance of explicit consent in particular cases, but rather it allows for a further discussion of the moral landscape where consent is problematic or absent. The relationship between a therapist and client seems particularly suited to a combination of 'regulatory' mechanisms, some explicitly contractual, others coming out of the underlying trust and mutual respect inherent in a well-constructed and well-managed relationship.

As previously observed, the relationship between the therapist and client will sometimes look little different from that between the client as a private individual and those who care about, and for, him or her in private life. Yet we understand that there is a need for boundaries to be in place because the therapist–client relationship is a variant of the doctor–patient relationship, which is *not* an element of an individual's private life. The therapist conducts the relationship in his or her role as a professional, which is a role defined and regulated in the public sphere. The client 'buys' the professional's services either directly or indirectly in a publicly regulated marketplace.

The space in which the relationship is conducted is relevant, not only because it makes it subject to the law, as it is outside the protected private sphere, but also because it makes the individual relationship subject to the structural features of the context within which it occurs. This is specifically relevant in the healthcare setting, where complex power structures exist which, in turn, help to define the relationship between the doctor and patient, the well and unwell, the client and therapist.

Power and harm

At the beginning, I introduced the notion of the public–private divide in order then to explore the ambiguity of the therapist–client relationship in terms of this dichotomy. What remains clear, however, is that the therapeutic purpose of the relationship and its existence in the public sphere mean that it should be managed and regulated, both directly by the individual therapist and indirectly by the relevant professional body. The moral justification for this lies in the need to prevent harm to either the client or the therapist.

The 'harm principle' is a key component of John Stuart Mill's account of liberty. In describing the 'appropriate region of human liberty' he famously stated that, as well as freedom of conscience, expression and association, 'the principle requires liberty of tastes and pursuits; of framing the plan of our life to suit our own character; of doing as we like, subject to such consequences as may follow; without impediment from our fellow-creatures, *so long as what we do does not harm them even though they should think our conduct foolish, perverse, or wrong*' (Mill, 1859; emphasis added).

Herein lies the idea at the core of the principle of autonomy, which has become so central to Anglo-American bioethics. While autonomy and liberty need to be distinguished from one another (and the role of autonomy should

not be overplayed), it is nonetheless important to acknowledge that, within liberal society, individuals have the right to govern their own lives in line with their values and beliefs, and that they may do so even if their actions are 'foolish, perverse, or wrong'. The limitation on this right comes from the corresponding duty thereby not to harm, or unreasonably impede, the autonomy of other individuals.

It is an empirical question whether a relationship between a particular therapist and a particular patient which breaks out of professionally defined and wisely acknowledged boundaries will lead to either party being harmed. It is too easy a step to define all clients as vulnerable and all therapists as powerful and then conclude that any relationship between the two is necessarily dysfunctional and potentially abusive unless it is clearly situated inside professional boundaries. However, it is also true that the boundaries are integral to the therapeutic process, and the key relationship between a therapist and client must remain just that – a professional and caring relationship between an individual with an expressed need and another individual with the expertise to address it. Just as we feel able to bare our bodies to a doctor because we feel confident to assume that he or she will have been trained to see it in a functional, non-judgemental and non-sexual way, so we must feel able to open our hearts and minds to a therapist expecting the same, essentially forensic, response.

If therapists allow a connection with a particular patient to go beyond the purely professional, they must question not only their ability to treat that particular person but also their more generalised professional duty to prioritise the best interest of the patient and avoid doing harm. To move outside their professional expertise into a private relationship is to embark on something inevitably uncertain and potentially dangerous.

Conclusion

A therapeutic relationship is built upon the needs of one party and the expertise of another. In practising his or her art, the therapist will inevitably enter the client's private realm of thought, and the intimacy this creates will sometimes lead one or both parties to desire further intimacy and a shift in the status of the relationship. In order to remain true to the initial purpose of the relationship, this cannot be permitted. This being so, it is important from the outset for the therapist to construct a boundaried notion of intimacy which is robust and fit for purpose. In doing so, the therapist creates a safe space in which much can be shared and within which the therapeutic project can advance. If the client tries to move the relationship to another place, the therapist must resist. Similarly, if the therapist feels drawn to the client in anything other than a properly professional manner, the therapist must resist. The therapeutic project can continue only for as long as the appropriate boundaries stay in place.

References

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