Psychodynamic Perspective on Therapeutic Boundaries

Creative Clinical Possibilities

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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. 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.

The conflict and controversy in the field are manifested in the heat generated by differing case formulations and the resulting technical interventions. 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. Other theorists favor an uncharted treatment approach of mutual discovery between therapist and patient. This path allows for novel outcomes that may be enormously valuable but may not resemble...
conventional treatment boundaries. Passionately held contradictory positions espoused by senior clinicians make formulating psychodynamic boundary interventions a conceptual and clinical minefield for therapists. 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. 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. 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. Treatment boundaries provide the built-in structure to contain and process communications. Intrapsychic and interpersonal therapeutic boundaries need to be permeable, allowing for mutual influence, and yet offer containment and holding for intense affective experiences. 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. (P. Russell, personal communication, 1983). 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.

Stolorow and colleagues 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. Other important therapeutic concepts and processes identified include an emphasis on the holding and containing functions of the therapeutic setting and relationship and the need for patients to relive developmental dramas in the therapeutic relationship, including disruption and repair of selfobject injuries. Additionally, the impact of the interpersonal, therapeutic experience to disconfirm transference expectations is crucial. 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. 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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{8,11,19–30}

### CASE EXAMPLES

Boundary literature often focuses on the management of therapist disclosures, out-of-office contact, giving and receiving gifts, and use of touch in therapeutic relationships. I will present several case vignettes depicting common boundary dilemmas and illustrate a dynamic, relational framework for understanding and intervening. The case vignettes illustrate the internal, interpersonal, and therapeutic process that the therapist and patient move through to elucidate meaning, develop formulations, and arrive at a clinically useful intervention.

**Case 1.** Sam, a professional man in his late twenties, was referred by a close friend for a “tune-up” after a lengthy, destructive psychotherapy with a female therapist that included numerous nonsexual boundary violations. Despite an eating disorder, bouts of severe depression, social isolation, and dangerous, sadomasochistic sexual relationships, Sam conveyed that he was interested in treatment to ameliorate his depressive symptoms. He made it clear he was terrified of another destructive treatment relationship and was skeptical about the therapist’s capacity to be of help to him and about his own capacity to change.

After many years of treatment, Sam announced his wish to attend and to eventually join the church down the street as a vehicle to expand social connections. The therapist felt his own anxiety rising because he was a member of this church. The therapist informed his patient that he also belonged to this church. Sam was interested but did not view this as a problem. In some ways, Sam’s decision to join a church was a step forward and a decision to be celebrated. However, the therapist was intrigued. Now that Sam understood that his therapist belonged to this particular church,
why didn’t he choose another congregation for himself? Although the therapist supported Sam’s wish to expand his community involvement, he felt privately that his patient’s membership in the same church that he and his family attended was untenable for the psychotherapy.

The therapist assumed a negotiating stance with Sam, directly discussing his feelings and concerns but stopping short of setting a limit while he tried to ascertain the meaning of the proposed step to his patient and discover what were the issues and affects being negotiated here. The therapist tried to explore fully the patient’s perspective and experience. Sam was aware of wanting a relationship with a spiritual community and had chosen this church based on its community reputation. He was out of touch with any feelings, wishes, or conflicts symbolically expressed by his desire to join his therapist’s church. The therapist wondered if Sam would like to be closer to the therapist and wished to know more about him but had been unable to ask. Perhaps it had been difficult to allow himself to be curious about the therapist, personally and professionally?

The therapist felt anxious and ineffective. Would they be able to negotiate this relationship crisis without a rupture in relatedness? Sam might be worried too. The therapist realized Sam might recast him in a negative light and leave treatment. Alternatively, the therapist wondered whether Sam’s therapeutic achievements were more than he could bear in terms of affective tolerance and shifts in positive self-image. Belonging to the same small congregation would significantly alter, perhaps in an untoward manner, the quality and nature of the therapeutic relationship. Was Sam destroying the treatment relationship to regain a familiar, albeit compromised, sense of self and internal affective climate?

Perhaps Sam wondered what his therapist privately felt about him or if he was like the therapist. Was Sam worthy of being in the same community as his therapist? Would the therapist allow or invite him to belong to his church? Or alternatively, because he knew the intimate details of Sam’s suffering and “disgusting behavior,” did his therapist view Sam as damaged, a pervert, and unacceptable to join his church? Was Sam capable of affecting his therapist in a deeply personal manner? Perhaps he was longing for an authentic, personal response.

Sam’s predominant experiences with relationships involved exploitation, betrayal, and abandonment. Was this request a reenactment of Sam’s earlier abusive relationships, with Sam turning passive into active and assuming the role of abuser? The therapist, feeling angry, wondered how much of this feeling was Sam’s projected anger and how much was his own reaction to feeling intruded upon.

Perhaps this was a test of the therapist’s capacity to protect the treatment from Sam’s self-sabotaging impulses and ultimately a test of containment and caring. Sam had expressed the depth of his anger at the therapist for “making this an issue.” In an effort to contain his own anger and communicate to Sam his understanding of Sam’s rage, the therapist commented, “I have some idea of how angry you are because I know how angry I am when I sit with you. I know it doesn’t feel this way to you but I am trying to protect the psychotherapy and our work together. One of the components that has worked well in this relationship is clarity about the limits and boundaries of our relationship and work together. Why would we want to alter a system that has enabled you to move closer to a sense of self and life that you desire and, I believe, deserve?” Sam was not sure. The therapist wondered whether Sam doubted he deserved his successes and was trying to undo his gains out of guilt or loyalty to old relationships.

The next Sunday the therapist, sitting in the front pews of the sanctuary with his wife and three children, heard a man wailing in tears behind him. He turned and saw his patient sobbing. The therapist felt intruded upon in a previously safe space.

Although the therapist did not fully understand his patient’s motivation, it was clear to the therapist that the two of them belonging to the same church would not work therapeutically, at least for this therapist. In church with Sam weeping, the therapist fantasized about being the container for Sam’s “disgusting,” contemptuous self-parts. He wondered how his patient could begin in church a new chapter of relatedness with his painful history when it was contained in his therapist who was sitting before him. Sam, on the other hand, reported that the reason he was weeping in church was because he felt moved by the lovely organ music.

Although the therapist understood that Sam viewed this differently, he felt sharing the same church would be disruptive to the psychotherapy. Sam angrily and steadfastly maintained he could handle these issues and feelings: “It’s your problem.” Acknowledging it touched on an issue of personal privacy, his therapist commented, “Perhaps you could view my need for personal privacy as a personal handicap, a limitation. It is part of who I am and how I work therapeutically. In order to be fully present and available to the treatment relationship and to respect your psychotherapy, I need to attend to my personal needs for privacy.” The patient was unwilling, despite the therapist’s efforts, to consider any point of view but his own.

After much careful thought about the experience and its effect on the patient, the therapist, and the psychotherapy, the therapist informed his patient that he felt they could not be co-congregants and continue the therapeutic work. He commented, “I know it is not possible for me to be your therapist and a fellow church member. I understand you feel it is possible for you. I may be wrong, but I also don’t believe it will be useful for your psychotherapy. I know you see this differently. Perhaps some therapists could see their way clear to do this. I can’t do it. We may have to agree to disagree about this matter.” The therapist presented the patient with a choice. If he decided to attend the church, the therapist would terminate the psychotherapy and, if he wished, refer him elsewhere for treatment. Sam responded with a sense of betrayal and rage that threatened to destroy all he had achieved as well as the therapeutic relationship. Although angry and feeling betrayed, he decided to remain in treatment to understand his feelings and experience be-
cause he felt this relationship had been of great value to him and their work was not finished.

Holding firm to the boundaries allowed Sam to relive, not merely remember, the problematic past in relationship with the therapist.22,28,30-32 The process of negotiation and exploration of Sam’s and his therapist’s feelings and experiences was respectful and containing. The therapist understood that the conversation was as important as any decision about where to set the boundary.23 Allowing Sam to fully experience and discuss his perspective provided a context for sorting out how they differed and adding a new dimension to the therapeutic work. Power was mutually shared through the process of each participant deciding what he felt he could and could not do.15,19,22 The therapist did not humiliate Sam for his feelings or longings by taking a “doctor knows best” stance. The therapist offered Sam a new relational experience by acknowledging and owning his personal feelings, including what Sam might experience as limitations. Sam did have a choice here. As the boundaries were renegotiated, the therapist could see more of what his patient needed from him.

Convinced that his therapist had reached an ambivalent decision, Sam was more open and willing to engage in the exploration of his deep sense of injury and rage. The therapist offered himself as an authentic presence who was committed to understanding Sam’s dilemmas and willing to tolerate his aggression in the service of protecting his treatment and his development. Sam needed to experience his therapist as failing him and betraying him. His therapist was able to tolerate the frustration, anger, and devaluing involved in assisting this man to differentiate his past relationships from his present ones and to have a different affective experience and outcome. Sam’s acceptance of his rage and sadism toward himself and others were crucial to his psychotherapy. Although disagreeing with his therapist’s decision, Sam acknowledged the value of being enraged at an important other without the destruction or denigration of either participant. Negotiating the intense affect and sense of betrayal while remaining in connection was a positive experience for Sam.

This vignette is not intended as a prohibition against therapists and patients attending the same church. Often, particularly in rural communities, therapists discover that their professional and personal lives overlap with those of their patients. Such overlap may be handled in and out of the consulting room in a range of clinically useful ways. The case of Sam illustrates the process of engaging patients in a sustained interpersonal and intrapsychic inquiry that leads to construction of affect, meaning, and deeper understandings. Such conversations and eventual understandings allow therapists to determine where to set boundaries in any particular treatment.

Case 2. Emma, an attractive woman in her late thirties, began weekly psychotherapy almost against her better judgment. In a state of chronic depression, rage, and anxiety, she worried about how little she understood about the effect she had on others and how greatly that blind spot affected her relationships. Furthermore, she struggled to control her anger, with very mixed results, and deeply worried that she was or would become the raging women her mother was. She reported a childhood history of severe emotional neglect and abuse with a rageful mother who always knew best.

She developed a close friendship, by uncanny coincidence, with a woman in a similar profession who was a group psychotherapy patient of her therapist. Emma began playing with thoughts of what she could ask for from her therapist. She initiated the conversation by bringing up information from her colleague’s treatment relationship with the therapist. Emma wanted to be treated the same. The therapist felt Emma’s determination to get her fair share at last. Emma was unable to identify or express her personal wishes. She was not interested in discussing her experience of her therapist’s particular manner of caring for her or how the therapist experienced or felt about her. She wanted treatment identical to her friend’s. Emma expressed sadness, frustration, and impotent rage at her inability to control her therapist or her colleague. The therapist commented that although Emma longed to be first, she wanted to punish someone for all the times she felt denigrated, marginalized, and not chosen. Someone should make up for her heartache. Emma was committed to the feeling that she would be second best.

As the therapist’s vacation approached, Emma felt “confused,” not about the therapist’s leaving, but about the knowledge that in previous years the therapist had informed Emma’s colleague about her vacation plans. Across the years of Emma’s treatment, she had never asked her therapist about her personal vacation plans and had never been told. Now, Emma was curious and wanted the same treatment as her colleague. The therapist inquired about Emma’s request, her feelings, and the meaning of knowing this information. Emma was unable to identify her curiosity, longing, or sense of loss about her therapist and the vacation. The predominant theme was, “I want what she got!”

The therapist felt Emma was replicating her painful childhood relationship with her mother. Emma was vacillating between recasting and inducting the therapist in the role of the abusive mother and assuming that role herself by bullying her therapist. Although knowing Emma was aguished, the therapist felt predominantly bullied and mistreated and unsure of how to proceed. Informing patients about her vacation plans was not unusual when it had a relational and therapeutic purpose. However, in Emma’s case the feelings of being coerced made her disinclined to share this information. She and Emma seemed deadlocked and unable to move beyond feelings of insult and anger.

Emma remained fixed on her angry, competitive feelings with her colleague and on her right to know. The tha-
pist fantasized about Emma’s unexpressed envy and jealous feelings toward her that were expressed through the colleague. Emma shared little knowledge of these feelings, commenting, “I’m not aware of any feelings about your life. This is about me.” The therapist felt Emma’s feelings were about Emma and about the treatment relationship. Emma, however, seemed unable to understand the dilemma dyadically.

Emma pulled out all the stops before the therapist’s vacation, demanding to know where the therapist was going on vacation and accusing the therapist of behaving in a patronizing manner. The therapist felt trapped in a no-win situation. She had no particular interest in withholding this information from Emma. Yet she felt strongly about not disclosing data under duress or if it did not make contextual, clinical sense. The therapist wondered if Emma might be experientially communicating just how she felt as a child, trapped in a no-win situation despite her best efforts to remedy it.

The therapist commented on Emma’s anger and grief. Emma responded, “I don’t feel angry. I feel confused and hurt.” The therapist shared her feeling that Emma was convinced she would be left out or left behind by the therapist and responded to that experience by pressuring her therapist. Although she understood some of the significance of the meaning of the request, she was most captured by Emma’s angry and threatening posture. Emma did not share her sadness and hurt, even though the therapist sensed they were there. The tone and packaging of the request made the therapist very uncomfortable with sharing any information. “I’m sorry you feel so hurt by me. It is not my intent. I think, and I know you disagree, that understanding these feelings and the process within and between us is very important. I don’t believe it’s useful for me to share personal data when I feel uncomfortable.” The therapist wondered if this might be a mini-example of what happens to Emma at work. She is hurt or disappointed, is out of touch with the deep anger this triggers, and proceeds by demanding what she wants from others. Then she is upset and surprised when her colleagues respond with anger toward her. Perhaps the therapist’s vacation and differing treatment of her colleagues made Emma feel diminished, hurt, and angry. Emma protects herself from hurt by assuming the less vulnerable position of being angry and proceeds to provoke anger in others.

In Emma’s case, only a beginning exploration of the dynamic and transference-countertransference occurred before the therapist’s vacation. Because of the level of aggression involved and the unfinished processing of the request, the therapist felt it was clinically most useful not to disclose the data requested. Perhaps the therapist had unwittingly contributed to the closing down of analytic space. Although she clearly felt angry, her annoyance was commingled with a sense of sadness and grief. She and Emma were a feeling-state away from owning and negotiating these affects and issues. She took some comfort in knowing the conversation was interrupted and not over. She hoped Emma would also discover that they could survive Emma’s self-expression and self-exploration.

The therapist wished she had been able to expand the space between them for engagement and understanding. The dyad was at an impasse that required an authentic, affective response from the therapist about the process. She felt it was important to reveal some of her observations and experiences but to draw the boundary short of revealing the vacation plans.

The therapist remained open to an examination of her own contribution to the interaction. Her internal boundary and processing remained open to an honest exploration of what she would learn from this treatment with Emma. Sharing her thinking was an effort to provide Emma with an alternative way of understanding her therapist’s behavior. The therapist hoped to model the experience of explicitly acknowledging and discussing feelings and observations about their relationship.

The boundary at this moment in this therapeutic dyad was determined by the therapist’s experience and understanding that containment and her patient’s full expression of anger, longing, and grief were being negotiated. The therapist acknowledged the patient’s feelings and understood her need to relive aspects of her childhood. Naming and holding these feelings and relational dilemmas without a rupture of relatedness would provide the opportunity for Emma to begin to experience herself and others differently.

Although therapists assume an open attitude with regard to the crucial boundary negotiations that illuminate the patient’s most painful transference issues, often, particularly when a patient cannot grasp any perspective but her own, the therapist’s construction of a boundary may make no sense to the patient. As in the case above, despite the therapist’s best efforts to engage in a conversation that could lead to deeper understanding and co-construction of a boundary, the patient feels wounded, feels a sense of loss, and, at least initially, experiences the therapist as sadistic or withholding. The
hope is that through mutual exploration, the patient will come to accept the boundary as protective of the psychotherapy and her future development.

Despite the therapist’s best effort to engage in an authentic process of negotiation and exploration about the meaning and construction of a therapeutically useful boundary, it is often not possible to know in advance where to set the boundary. Trial, error, and time may also bear out that a boundary was too flexible or too rigid. The most thoughtful, well-intentioned boundary decisions may have untoward effects. On occasion, some patients may be unable to negotiate such an understanding and may abandon therapy.

EXPLORING EXCEPTIONAL REQUESTS

Patients regularly deliver into the psychotherapeutic relationship their most painful and shameful feelings about themselves and their relationships through a request for a stretching or extending of the usual treatment frame. These requests often represent extraordinary events or interventions that would never be routinized in everyday practice. Therapists who are comfortable with more uncharted treatment approaches within ethical frames and favor a process of mutual discovery between therapist and patient may explore and keep open the possibility of, for example, attending a patient’s event, giving or accepting a gift from a patient, or sharing personal information in the service of therapeutic goals. These events are extraordinary in that they are rare occurrences in a therapeutic relationship undertaken for a particular therapeutic purpose after thorough investigation. Therapists who are willing to construct untraditional but clinically useful boundaries demonstrate a willingness to cope with the unknown and to be influenced and educated by their patients about the therapeutic value of these events. The interpersonal and intrapsychic exploration of the meaning of these events and the associated feelings to the therapist-patient dyad establish a context for safety, which opens up space for a deeper, more intimate conversation whether or not the therapist decides to honor the request. Through sustained engagement with the patient about such requests, the therapist may come to understand the layers of meaning and significance of such overtures. The effort to study the meaning and qualities of mutual experience in these moments creates the space and conditions for an intimate encounter that might be impossible without an openness to the dynamic, creative setting of therapeutic boundaries.

It is difficult for the independent practitioner who is often struggling with intense feelings and overwhelming clinical dilemmas to know how to integrate a psychological containment field with sensitive, useful, clinical interventions. Therapists ambivalent about where to set therapeutic boundaries and confused about the nature of therapeutic action retreat from open, honest conversations with patients. Sometimes therapists simply have little idea of how to proceed in an unformulated fashion and have had few mentoring or supervisory opportunities to assist in the development of a psychodynamic understanding of boundaries and boundary maintenance. In other cases, the more comfortable position for the therapist is to remain protected behind a professional mask or veneer that forecloses the experience of intense affect, therapeutic possibilities, and deep conversations.

Patients’ presentation of painful, personal conflicts and interpersonal dramas may be unconventional and may startle or overwhelm the therapist. When startled, therapists may set unhelpful therapeutic boundaries as a way to manage their own anxiety. Consider the following case:

A transsexual male wanted to attend psychotherapy sessions cross-dressed. The therapist viewed this request and behavior as a boundary violation and prohibited the patient from coming to sessions cross-dressed, thereby foreclosing the valuable exploration of this man’s experience of himself as a blend of man and woman with the affects and conflicts accompanying this self-experience. The therapist was unable to join the patient’s experience and explore the layers of meaning of this behavior. This clinical boundary decision was framed as protective of the patient and the psychotherapeutic process. However, it is also easy to understand this clinical decision as primarily protective of the therapist.

Therapists may be startled by the intensity of their own affective responses and uncertain how best to make therapeutic use of such feelings. At those treatment moments they wish to construct an internal barrier to feeling, as well as an interpersonal barrier between themselves and patients.

Being open to influence from within and between participants in a psychotherapy provides contextual safety and the possibility of creative, novel, deeply personal, and transforming conversations. Engaging pa-
tients and ourselves in a sustained interpersonal and intrapsychic inquiry leads to co-construction of affect, meaning, and deeper understandings. It is precisely such conversations and eventual understandings that allow clinicians to determine where to set boundaries in any particular treatment dyad.

CONCLUSIONS

Constructing therapeutically useful boundaries in clinical practice is a complex and controversial process. Clinicians are well informed about ethical conduct and yet remain confused about how to psychodynamically understand and construct therapeutically useful boundaries in psychotherapy.11–18 A reductionist, rule-bound approach to therapeutic boundaries is not useful. Within an ethical framework, the conversation about boundary decisions is as important to the psychotherapy as any decision about where to set the boundary.20,22,23

An integrated psychodynamic, developmental, relational perspective allows the therapist to explore and construct boundaries in each therapist-patient dyad. An integrated approach, one that honors traditional parameters and yet encourages an openness to creative, uncharted, outcomes within ethical frames, is useful and captures many clinicians’ actual experience. Clinicians strive to navigate through this minefield of controversy by choosing a mix of traditional and innovative parameters and concepts to guide them in their care of patients. More discussion in the literature of treatments that borrow from several schools of thought and model integration of practice methods would be valuable.

An intrapsychic and interpersonal focus on therapeutic boundaries allows reciprocal influence, construction of meaning, and novel interpersonal and affective outcomes. Such an approach also offers containment and holding of intense, unconscious, affective experiences and interpersonal dramas. The interpersonal and intrapsychic exploration of the associated feelings and meaning of these clinical issues opens up space for expanded possibilities and deeper therapeutic dialogue. Such dialogues provide unexpected therapeutic opportunities that may add a novel, valuable dimension to the therapeutic relationship that advances the clinical work.

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