





The developing concept of appropriate boundaries increasingly forces therapists into defensive practice and to work in ways that are based not on giving the client the therapeutic environment best suited to them, but on avoiding vulnerability to misconduct hearings, argues *Nick Totton*.

Illustration by Paul Blow

Boundaries and boundlessness

'The inability to tolerate empty space limits the amount of space available.'
Wilfred Bion¹

There is a quietly ferocious struggle going on for the soul of psychotherapy and counselling, manifesting in many ways – regulation, training, evidence-based practice – but ultimately about the tension between spontaneity and control. I want to examine how this tension operates in clinical practice, and in particular the ways in which a self-censorship or ‘therapy police’ is installed in practitioners – primarily through an insufficiently examined notion of boundaries.

Many supervisors have noticed how supervisees inhibit their own responses, and in fact their own best judgement, in line with an internal modelling of what they believe is expected of them by their profession. This is natural enough, and in some ways appropriate, for trainees or newly qualified practitioners who need to develop an ‘internal supervisor’, though even here it can be unhelpfully exaggerated. But for experienced therapists or counsellors it acts as a

block to authentic relationship with their clients, founded on a sense of their own professional inadequacy.

Joseph Sandler, an elder of psychoanalysis, wrote in 1983 that ‘the conviction of many analysts [is] that they do not do “proper” analysis... that what is actually done in the analytic consulting room is not “kosher”, that colleagues would criticize it if they knew about it.’² He goes on to say: ‘Any analyst worth his salt will adapt to specific patients on the basis of his interaction with those patients. He will modify his approach so that he can get as good as possible a working analytic situation developing. I believe that the many adjustments one makes in one’s analytic work... often lead to or reflect a better fit of the analyst’s developing intrinsic private preconscious theory with the material of the patient than the official public theories to which the analyst may consciously subscribe.’²

Sandler is pointing out that in reality we spend a lot of our time flying by the seat of our pants, as it were – relying on our ‘educated instincts’ to shape our response, rather than taking time out to consult the rulebook. There are

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aspects of the training and culture of therapy, though, which militate against these ‘adaptations and adjustments’, or at any rate make the practitioner guilty and secretive about them.

Gifted and well-established (and courageous) practitioners may be able to speak openly about how they have stepped outside the conventional framework – as when Brian Thorne writes about working naked with a client,³ or Peter Lomas about taking a session out of doors,⁴ or Mario Jacoby about physical contact with a client⁵ – but they are partially protected by the exceptionalism which attaches to celebrity: ‘It’s all right for *them*’. And even therapeutic celebrities have kept silent about some of their actions. Winnicott, for example, never revealed that he too touched some of his clients.⁶

Beginning with Freud, though – as we can see from his clients’ narratives collected in Lohser and Newton⁷ – it is clear that the therapy world operates on the principle ‘Do what I say, not what I do’, with many senior figures using a much more spontaneous and relational way of working themselves than they are willing to recommend to others. I have more than once had the experience, when speaking at a conference about my use of touch in therapy, of being told privately by some elderly and experienced figure: ‘Well, I’m happy

for *you* to work in this way, I can see you know what you’re doing, and I might do some of it myself – but I would never publicly condone it.’

Touch is a useful example because it so clearly constellates anxieties about ‘wild’ and out-of-control feelings and behaviour. These anxieties – both within the therapy profession and in the wider society – have intensified over recent decades, and become condensed into the quintessentially domesticated concept of ‘appropriate therapeutic boundaries’. One thing that most newly qualified counsellors and psychotherapists are clear about is the importance of therapeutic boundaries. They may not necessarily be very good at maintaining them, but they know that doing so is essential. Unfortunately, this ‘knowledge’ is untrue or at any rate incomplete.

Relatively new practitioners are so familiar with the notion of boundaries that it may come as quite a surprise to find out how recently it was introduced. A literature search shows that before the 1990s, therapists did not really speak of ‘boundaries’ in this specific sense, meaning ‘lines of behaviour which must not be crossed, by the therapist, by the client, or both’. Of course issues of acceptable behaviour were discussed long before then, but under a variety of different headings; and there is something very significant about the way

in which all these themes were gathered together under a single rubric, which seems to have been borrowed originally from the discourse of sexual abuse.

The slippery slope theory

The theory of boundaries, which has grown up around work with survivors of sexual abuse, is enormously helpful and clarifying – *within that context*. But its appropriation as a way of thinking about issues like fees, telephone contact or session times has had the effect of installing a subliminal notion of what both its advocates (eg Simon⁸) and its opponents (eg Zur⁹) have called the ‘slippery slope’ theory: that any flexibility or inventiveness around the usual ways of doing therapy – a single toke on the spliff of adaptability, so to speak – leads to the hard stuff: to sexual abuse of clients. It has been claimed in all seriousness by proponents of the ‘slippery slope’ theory – writing not in the 1920s but in the 1990s – that the use of first names between practitioner and client is a predictor of sexual abuse further down the line.^{10,11}

Freud is often blamed for this state of affairs because of the technical papers on psychoanalysis which he wrote to guide young practitioners.^{12,13} Whatever one feels about his recommendations (which is explicitly what they were), it is interesting to find that Freud very often

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quite openly frames them not as a protection for the *analysand*, but for the benefit or convenience of the *practitioner*: ‘The psycho-analyst who is asked to undertake the treatment of the wife or child of a friend must be prepared for it to cost him [*sic*] that friendship, no matter what the outcome of the treatment may be: nevertheless he must make the sacrifice if he cannot find a trustworthy substitute.’¹³

And a little later in the same paper: ‘[H]e should also refrain from giving treatment free, and make no exceptions to this in favour of his colleagues or their families. This last recommendation will seem to offend against professional amenities. It must be remembered, however, that a gratuitous treatment means much more to a psycho-analyst than to any other medical man; it means the sacrifice of a considerable portion – an eighth or a seventh part, perhaps – of the working time available to him for earning his living, over a period of many months.’¹³

Fundamental ground rules

Freud is mainly thinking practically, flexibly, and locally; he might have been quite surprised to find Robert Langs arguing that these local arrangements match the unconscious needs of *every single patient*. Langs’ follower David L. Smith lists a set of 21 ‘fundamental

ground rules’ including such matters as a set time, a set fee, and no gifts being accepted, which he claims all psychotherapy clients ‘unconsciously want their therapists to follow irrespective of their conscious preferences. They appear to be universal rules.’¹⁴ In a note, he continues, ludicrously but quite logically, ‘this implies that patients’ unconscious secured-frame criteria are the product of hominid evolution.’¹⁴

The idea that we have evolved as a species to require a set time and fee in therapy is not widely held; but it *is* now widely held that all clients at all times should be treated within the same set of boundaries. Over about 20 years, the idea that boundaries are a key element in therapy has become more and more dominant, to the extent that for many practitioners it is now part of their conceptual wallpaper, an axiom which they have perhaps never questioned. The emphasis on boundaries has been read back into earlier therapeutic formulations, and is now understood as universally present. But is this really the case?

The humanistic therapies, and in a different sense behavioural therapy, developed partly in reaction to what was seen as the rigid structure of psychodynamic work. Humanistic therapy stresses the importance of

offering warm, genuine contact; while behavioural therapists, at least originally, saw their work as avoiding all the apparatus of transference and projection and simply applying expert techniques, so that the relationship is one between equals, equivalent to that with one’s accountant or architect: ‘The resulting relationship is one in which I have felt quite comfortable having good friends as clients and good clients as friends.’^{15,16}

Defensive practice

But the developing concept of appropriate boundaries, and in particular its codification in legal and quasi-legal structures, increasingly forces all therapists and counsellors into *defensive practice* – that is, working in ways which are based not on giving the client the therapeutic environment best suited to them, but on avoiding vulnerability to misconduct hearings. In a crucial contribution to the theory of therapeutic boundaries, Gutheil and Gabbard¹⁷ developed a distinction between ‘boundary violations’, which they see as always harmful, and ‘boundary crossings’, which may be neutral or beneficial. However, they also argued that even boundary crossings which are justified and consistent with good care, should be avoided, on the basis of their possible adverse appearance in court. This

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process of avoiding behaviours not because they are wrong, but only because they *appear* wrong, is known as 'risk management'.

According to Gutheil and Gabbard, 'the risk-management value of avoiding even the appearance of boundary violations should be self-evident.' But there are other values central to therapy that may occasionally demand 'the *appearance* of boundary violations', or at least certainly that we do not '*avoid*' that appearance. Therapy is as much about questioning boundaries as it is about asserting them; as much about supporting clients to break out of the rules as it is about teaching them to observe the rules. For some clients at some times, it is crucial to know that the therapist will act within a defined frame. For others, or for the same clients at other times, it is equally crucial that the therapist dances outside the frame, and that a trust can be established which is based on authenticity rather than predictability.

Therapy based on authenticity may reasonably be characterised as 'undefensive practice', as opposed to the 'defensive practice' which is becoming more and more the norm of contemporary therapy. Undefensive practitioners are vulnerable to misunderstanding, and indeed, if not sufficiently self-monitoring,

to misbehaviour; but defensive practitioners, in the extreme, neither like nor trust their clients – they see them as a potential threat, a danger to be negotiated. On one level this threat is to the practitioner's standing and income, should a complaint be made; but more deeply, one feels that the real threat is to the practitioner's insecure self-image and self-esteem. Their internal critic is projected out into their clients, who are then mistrusted and feared.

A more realistic picture

A more positive and realistic picture of the situation is put forward by Johnston and Farber,¹⁷ who surveyed what practitioners think and do around 'everyday' boundaries in psychotherapy – starting and ending sessions on time, payment of fees, changing session times, and so on. They found that: 'Patients make relatively few demands and psychotherapists accommodate them most of the time. This finding stands in opposition to the generally accepted image of the psychotherapist standing firm in the face of persistent attempts by the patient to challenge existing boundaries and suggests a spirit of cooperation and good faith under-emphasized in theoretical writings.'¹⁷

Jodie Messler Davies¹⁸ describes the extreme difficulty of working, while having a heavy cold, with a client she

refers to as Karen, who seems to use Davies' illness to confirm her negative picture of their relationship, and calls her 'such a bitch... cold and unfeeling', leaving Davies 'stunned'. However, after some splendid self-supervision on Davies' part, something transformative happens in the next session: 'On Friday afternoon I am still sick... I brace myself for Karen's entrance... But I notice, almost immediately that something feels palpably different. The air feels warmer, her eyes look softer and more searching, my own body seems to relax even before I can formulate the experience... Karen reaches down into her book bag and pulls out a large silver thermos and mug. As she opens the thermos and begins to pour, the warm smells of honey, vanilla and cinnamon fill my office. I am mesmerized as I watch Karen, intrigued with her swift and competent movements. "This will be good for you," she says. "My grandmother used to make it for me when I was sick. It is a combination of hot tea and hot milk with a lot of other wonderful stuff."¹⁸ At this point, alerted by CCTV, the Therapy Police smash down the door and storm into the consulting room. All of the familiar objections to 'gratifying' the client flash through Davies' mind, and all of the ways in which an 'interpretation' could maintain the therapist's control of the situation. 'I try to will myself to

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‘Many senior figures use a much more spontaneous and relational way of working than they are willing to recommend to others’

think, despite the feverish “buzz” in my head. My patient is attempting to feed me warm milk! There must be an incredible interpretation in this somewhere!’¹⁸ For paragraphs of text, though probably only a few microseconds of real time, she wrestles with her internal judges, with her intellectual process. Then she takes the milk: ‘She holds the mug out to me, an expression of intense pleasure and hopefulness suffusing her face. As I reach for the mug our fingers touch for an instant and I recall that my own grandmother brought a similar recipe with her from Russia; one she would prepare for us when someone in the family was sick with a cold... I take Karen’s mug in my own hands, breathing in its healing, aromatic warmth... the intoxicating smells and moist heat penetrate and soothe. I take a long, deep, healing gulp of Karen’s milk... I smile at Karen through the steam, and she smiles back.’¹⁸

We can take this as an example of undefensive practice – informed and guided, as of course it must be, by a critical understanding of the many levels involved, but not *controlled* by that understanding. The focus is a deeply embodied interaction. There is a lot about touch, taste, and smell. Karen brings a ‘palpably different’ atmosphere when she arrives, the air

feels warmer, her eyes softer, her smile warmer and evoking an answering smile from the therapist. The mug of milky tea, the ‘wonderful stuff’, is described in highly sensuous terms; as it is passed over, ‘our fingers touch for an instant’, and both client and therapist recall their grandmother. This is a multisensory, multidimensional, psychosomatic interaction, bringing with it an abundance of positive memories and associations for both people. It is a moment of healing.

Of course, it is only the beginning of a long process of coming to understand a very difficult relationship. But it seems clear that this undefensive, embodied interaction, where so much is both communicated and expressed, through so many sensory channels, creates a bridge of intersubjectivity over which other communications can then pass. Embodied relationship, in fact, is ‘wonderful stuff’: the milk of human kindness! And sometimes we must take the risk that the milk *might* be poisoned, the client might be seeking to manipulate us in some way. The risk we take is the authentic expression of our wish for contact with the other.

The potential for relatedness

Every therapeutic relationship needs to be a *relationship*: a place where two subjectivities meet, with all the difficulty

and painfulness this implies, but also with a developing willingness and capacity to tolerate the other person’s otherness. For a therapist to hold careful boundaries because they believe they *must*, or because they are afraid of the uncontrollability of closeness, cripples the potential for relatedness. But for a therapist to hold such boundaries as an honouring of the client’s woundedness is itself relational. The only valid generalisation about relationships is that they are each unique; and therapists are artisans of relationship, co-creating one-off works with their clients.

What is the opposite of being boundaried? One answer is ‘unboundaried’; another is ‘boundless’. Undefensive practice, I suggest, draws on a sense of boundlessness – abundance, space, attention and care. In contact with abundance, the therapist can afford to be generous on many levels, which communicates the experience of abundance to the client, perhaps allowing them to relax about life and its challenges. Yes, a practitioner who cannot offer her clients boundaries is dangerous. But a practitioner who cannot offer her clients boundlessness is useless. ■

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