

Commentary: Boundaries, Culture, and Psychotherapy

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I welcome the opportunity to further the dialogue on the role of boundary theory in psychotherapy. Dr. Kröll has given considerable thought to the negative ramifications of rigid adherence to professional boundaries, and I think he makes many valid points. I approach this commentary, however, with a sense of irony. I am in the curious position of attempting to respond to challenges from a person who is in essential agreement with me. This statement may come as a surprise to the reader, though, because of Dr. Kröll's selective citation of my work.

Dr. Kröll rightly points out that adopting an attitude that boundaries are analogous to laws that must be scrupulously followed lest one be punished is a misunderstanding of boundary theory. He and I share the concern that many therapists may fail to engage the patient by approaching professional boundaries as though they are ironclad or etched in granite. As I noted in one chapter frequently referenced by Dr. Kröll:

Unfortunately, some contemporary clinicians have misconstrued the concept of professional boundaries to suggest rigidity and remoteness in the relationship between the clinician and patient. This interpretation is a serious misreading of the role of boundaries in practice. The frame must be sufficiently flexible that it accommodates individual differences among patients and among clinicians. Similarly, it in no way implies coldness or aloofness. Rather, the boundaries are structural characteristics of the relationship that allow the therapist to interact with warmth, empathy, and spontaneity within certain conditions that create a climate of safety (Ref 1, p 143).

Indeed, Gutheil and I² wrote a paper entirely devoted to expressing our concern about the misuses and misunderstandings of professional boundaries in

both regulatory and clinical settings. Hence, I am perplexed that Dr. Kröll feels that the potential for rigid adherence to strict boundaries to end in a failure of therapeutic engagement has been "ignored" in the literature. Indeed, as I read Dr. Kröll's paper, I often thought that his wish to use the work of Gutheil and me as a foil for his argument led him to overlook the fact that much of what we have written is in direct agreement with him.

At times Dr. Kröll's method of argument is to use examples of "boundary crossings" that hardly anyone would characterize as such. For example, he suggests that offering a tissue or a medication sample should not be regarded as boundary-crossing behaviors, unless we use a very restrictive definition of boundaries. I certainly agree. Offering a tissue is a human response that is appropriate within any form of therapy, regardless of theoretical orientation. Providing a medication sample is a treatment decision that has little to do with boundary considerations. I was even more mystified when he suggested that "routine interactions between therapist and patient" might be "labeled pejoratively as boundary crossings." In all of my writings and in those that I have coauthored with Gutheil, we explicitly make the point that boundary crossings should not be regarded pejoratively, because they are often therapeutically useful and humane gestures.

In our 1998 paper,² Gutheil and I insist that the context must always be taken into account when trying to determine whether a particular behavior constitutes a boundary violation:

Thinking about boundaries can lead one to an absurd endpoint, unless one understands the critical role of the context in which behavior occurs. The context may be constituted by the treater's professional ideology, the presence or nature of informed consent by the patient, the point in the therapy at which behavior occurs, the respective cultures of the dyad, and such environ-

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mental factors as whether therapy occurs in a small town or in an urban center and whether public transportation is available (Ref. 1, p. 411).

At several points in the paper, Dr. Kroll seems to misunderstand arguments put forth by Gutheil and me. He ends up reaching the same conclusions but packages his conclusion as though it is at odds with our own views. A good example is his challenge of our view about self-disclosure by the therapist:

Gutheil and Gabbard state unequivocally: "Few clinicians would argue that the therapist's self-disclosure is always a boundary crossing." The empirical basis for this assertion is unclear. The conceptual problem of what constitutes a boundary crossing is not mitigated by Gutheil's and Gabbard's assurances that boundary crossings can be legitimate and helpful therapeutic behaviors. My basic point here is that not all therapists are in agreement that therapist self-disclosure is indeed, let alone always, a boundary crossing.

I fail to see how his conclusion is different from ours. We are both saying that there are very different perspectives on therapist self-disclosure and that many, if not most, therapists would question whether therapist self-disclosure is always a boundary crossing.

As has Dr. Kroll, I have advocated for considerable flexibility on the issue of self-disclosure. In this respect, I think we see eye to eye. There are no rigid guidelines that are particularly helpful when one considers self-disclosure. One negotiates the optimal level of self-disclosure with a particular patient as a matter of clinical judgment. A general principle is that the therapist should avoid burdening the patient with the therapist's own problems and avoid a role-reversal situation in which the therapist seeks help from the patient for personal difficulties.

I also share Dr. Kroll's concern about the prescribing therapist's neutrality. The blank-screen analyst so often depicted in Hollywood caricatures of psychotherapy is a construct that has been dead and buried for a number of years.^{3,4} It is impossible for a therapist not to introduce his or her own subjectivity into the therapeutic process. Indeed, most analytic therapists would agree that therapists should allow themselves to be "sucked in" to the patient's internal world through attenuated enactments that dislodge the therapist from the classic posture of a quiet, reflective listener.⁴ Through enactments of various kinds, the therapist begins to understand the characteristic pattern of object relations of the patient and is able to provide a greater understanding for the patient's benefit about what typically happens in relationships with people outside the therapeutic dyad.

Although Dr. Kroll ascribes to me a statement that the therapist who does not charge a fee may be acting from a neurotic need to be liked by the patient, he provides no reference for that comment. It is certainly possible that a particular therapist could act out of a neurotic need to be liked when lowering the fee, but once again I find myself in broad agreement with Dr. Kroll that the fee can be reduced for entirely legitimate reasons that may advance the therapy in a positive direction. As is true of most of the boundary issues that arise, such determinations must be made on a case-by-case basis as Gutheil and I have argued,² and with which Dr. Kroll agrees!

Dr. Kroll's tone suggests that there is insufficient recognition of how boundaries vary with the school of therapy and with the culture. Gutheil and I² have pointed out the same thing, and we² have cited explicit examples of how cultural considerations must be taken into account in establishing boundaries. Similarly, we² have stressed how a behavior therapist, a psychopharmacologist, and a case manager in a mental health center have a different set of boundaries based on a perspective different from those of psychoanalytic or psychodynamic psychotherapists.

Much of Dr. Kroll's concern seems to focus on the establishment of strict guidelines based on boundary theory, specifically the guidelines proposed by Simon^{5,6} and by Simon and Williams.⁷ Except for sexual contact with patients and financial dealings with patients other than the fee, professional boundaries in psychotherapy are fluid and largely a matter of clinical judgment and context. I share Dr. Kroll's view that it is extremely difficult to apply rigid rules of behavior to most boundary situations. Boundary crossings are much more usefully thought of as a way of monitoring one's countertransference. When therapists find themselves interacting with a patient in ways that depart from their usual professional conduct, such as hugging the patient, sharing personal problems with the patient, and presenting a patient with gifts, they should scrutinize their behaviors with a skeptical eye and seek out consultation with a colleague to help them think through the motives behind their behaviors.

Only through the practice of self-monitoring around boundaries can we hope to prevent boundary violations. It would be absurd to argue that every therapist who crosses boundaries with a particular patient inexorably progresses to major boundary violations. Does everyone who uses marijuana progress

to heroin? Of course not. Dr. Kroll chastises Gutheil and me for engaging in *post hoc* logic. We base our observations on hundreds of actual cases of egregious boundary violations that have come to our attention. The benefit of the “slippery-slope” model is that it helps therapists think about early warning signals and stop the descent into more serious boundary transgressions.

Dr. Kroll concludes that boundary considerations are most helpful when they are presented in terms of broad ethical considerations, such as “do no harm” or “do not exploit the patient.” I wish it were that simple. None of us can be entirely aware of what we are up to when we go to extraordinary measures to help a disturbed or suicidal patient. In my experience in evaluating and/or treating nearly 150 psychotherapists who have engaged in boundary violations, one of the most striking findings is how convinced the therapists are that what they are doing is for the patient’s good. In most cases, even to an untrained observer, these therapists have deluded themselves into thinking that behaviors in their self-interest are really altruistic and in the patient’s best interest. Psychotherapists are just as prone to self-delusion as all other members of the human species. The construct of professional boundaries allows for therapists to know when they are behaving in such a way that there is a potential for harm. Unfortunately, even those with extensive knowledge of transference and

countertransference may be totally oblivious to the unconscious aggression in acts that they view as kind or rescuing—a point of view shared by Dr. Kroll in his thoughts about prevention.

We practice in a radically private setting. Confidentiality is a cornerstone of what we do. Unless we make room for consultation as part of our routine practice, however, the privacy of the dyad can lead us into the darkest regions of countertransference, from which no return is possible. The notion of professional boundaries is a beacon in that darkness that can certainly be misused, but it has also salvaged many treatments in the early stages of potential catastrophe.

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