Commentary: Treatment Boundaries—Flexible Guidelines, not Rigid Standards

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Dr. Kroll's basic complaint in his article is that I and others have created "a canonical list of guidelines for proper therapy" that are harmful to psychiatrists and their patients. I state clearly in my articles that boundary guidelines are not standards. For example, one of my articles cited by Dr. Kroll, which he presumably read, states:

> An absolutist position concerning treatment boundary guidelines cannot be taken. Otherwise, it would be appropriate to refer to boundary guidelines as boundary standards. Effective treatment boundaries do not create walls that separate the therapist from the patient. Instead, they define a fluctuating, reasonably neutral, safe space that enables the dynamic, psychological interaction between therapist and patient to unfold. Since treatment boundaries have a certain variability, unanimity of professional opinion does not exist on a number of boundary issues. Moreover, practitioners may place a different emphasis on certain boundary guidelines.[1]

There are always exceptions to any boundary guideline. Currently, there are more than 450 psychotherapies. Thus, it is not surprising that the therapy techniques of one therapist may be anathema to another therapist who considers such practices to be clear boundary violations. Much variability in defining treatment boundaries appears to be a function of the patient, the therapist, the type of treatment, and the status of the therapeutic alliance. I have always maintained that psychiatry should continue to be highly receptive to innovative treatments that offer the hope of helping the mentally ill. Sound, but flexible, treatment boundaries should facilitate such innovation in psychotherapy. I agree with Dr. Kroll that inflexible, rigid treatment boundaries are inimical to good clinical care.

Dr. Kroll expresses the concern that "The problem here is that when these 'guidelines', supported by examples of therapeutic disasters, come out in print, then standards become set for our entire profession and therapists who do not agree in principle or practice with such standards may be pilloried in court by attorneys who cite the published guidelines." Such a dire statement is overwrought and unfounded. I have never proposed treatment boundary standards. I have made sufficiently clear the difference between standards and guidelines. The guidelines I describe are prefaced by caveats concerning their variability, flexibility, and context that preclude dogmatic assertions about boundary maintenance. Moreover, only egregious boundary-violation cases are litigated. Very few go to trial. Most of these cases are settled.

Attorneys, in their exercise of zealous advocacy on behalf of clients, have wide latitude in their conduct of cross-examination of witnesses. Within evidentiary constraints, attorneys may freely use all or parts of published materials that suit their purposes. Dr. Knoll's article may be used against therapists and other witnesses who do not subscribe to his views, perhaps in ways he did not originally intend or expect. Nor is Dr. Kroll immune from being "pilloried" by his article, should he venture into court.

Dr. Kroll complains about my guideline, "maintain relative therapist neutrality". I may not have emphasized sufficiently the important qualifier "relative." He misinterprets therapist neutrality as a position of distance and indifference to the patient's

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plight. He proclaims, "Who wants a neutral therapist?" For example, he writes:

> Insisting on "neutrality" or considering departures from neutrality as a boundary crossing, is to extract a small piece of early psychoanalytic theory for use as a safeguard against injudicious involvement on the part of the therapist. The guideline seems to suggest that most therapists of various schools of thought cannot be trusted to perform competent, supportive behavioral and exploratory therapy without an external mandate that eliminates the resourceful use of their own therapeutic judgment tailored to fit each unique situation.

I believe that an important principle that supports and facilitates effective psychotherapy is the "rule of abstinence." It states that the therapist must refrain from obtaining personal gratification at the expense of the patient. A corollary to the rule of abstinence is that the therapist's main source of personal satisfaction is derived from the professional gratification of engaging in the therapeutic process and from the pleasure gained in helping the patient.

Another corollary to the rule of abstinence is relative therapist neutrality. I clearly state in my articles that I do not define therapeutic neutrality in the psychoanalytic sense of equidistance between the therapist's ego, superego, id, and reality. The qualifier "relative" neutrality makes clear that I do not advocate that therapists act robotically toward their patients. As I have written in a number of articles, psychotherapy relies on the human interaction between patient and therapist to be effective. Therapist neutrality refers to avoiding imposing the therapist's values on patients or interfering in their personal lives, based on the therapist's personal agenda. Obviously, for patients whose decision-making capacity is severely and dangerously compromised, the therapist must intervene professionally.

Dr. Kroll's second complaint is about the guideline, "preserve relative anonymity of therapist." He recognizes the important qualifier "relative" but quickly dismisses it as "not especially helpful." Dr. Kroll ignores the qualifier by stating the obvious—that "anonymity is, in fact, a myth." He states:

> In a broad sense, every sentence, facial expression, and bodily posture; every choice of furniture and furnishings; the decision to hang one's diplomas on the wall or to have photographs of one's spouse and children on a desk; the selection of clothes and adornments; and the decision whether to work on various religious holidays all reveal information about the therapist and thus constitute a departure from anonymity and could represent a boundary crossing or perhaps a boundary violation.

Of course, therapist anonymity is impossible. Nor is it desirable. In my articles on boundaries in treatment, I freely admit that therapist self-disclosure is a complex topic.[2] The therapist's position of relative anonymity does not require that the therapist be a blank screen. The therapeutic relationship between therapist and patient is interactive. Some therapists have found that sharing a personal experience may prove helpful to a patient. However, a problem arises when a therapist, in a moment of self-disclosure, describes current personal conflicts or crises in the therapist's life that can create a role reversion in the patient. The patient may attempt to rescue the therapist or, at a minimum, is burdened by the disclosures. Details of the therapist's personal life, especially sexual fantasies and dreams about the patient or others, obviously should not be shared.

Dr. Kroll's third criticism is directed at the guideline, "establish a stable fee policy." My position is that a stable, not a capricious, fee policy be followed. I have no argument with therapists who want to provide treatment to patients at no charge, notwithstanding the therapeutic obstacles that can arise from such an arrangement. In fact, most psychiatrists, including me, provide substantial *pro bono* care to patients.

Bartering arrangements with patients do not usually work out well. It is difficult for the therapist, and especially for a distressed patient who desperately needs treatment, to place a realistic value on the goods that are bartered. As a treatment issue, therapist and patient should have a clear understanding of fee arrangements that are part of a stable fee policy. Fee misunderstandings or disputes often disrupt treatment, undermining the therapist-patient relationship. Establishing treatment boundaries that are stable, but not inflexible, provides a secure therapeutic frame for patients who have experienced mainly insecurity and distrust in their lives.

In response to a vignette in the article by Dr. Williams and me,[3] Dr. Kroll criticizes our suggestion that "psychiatrists may ethically elect not to continue to treat a non-emergency patient who is unable to pay for treatment." Although Dr. Kroll or I may not choose to do this, it nevertheless is a realistic, ethical option, provided the patient is not abandoned. Therapists are not required to provide treatment at no cost. Dr. Kroll states:

> It may be legally permissible to discontinue treatment under such circumstances, but discontinuing treatment may itself cre-

> ate a crisis or emergency situation. It is the assumption of universal applicability of the authors' [Simon and Williams] particular value system that is most troublesome.

Apparently, I have not made clear enough that I do not espouse the universal applicability of our "value system." Treatment guidelines are presented for therapists to consider. They can take them or leave them. The main issue is whether the setting of treatment boundaries with a specific patient facilitates treatment.

In his article, Dr. Kroll writes about harm caused by "the recent practice of constructing highly specific guidelines that reflect one author's or one group's preferred methods and values. . . ." I have perhaps not emphasized sufficiently that the boundary guidelines presented in my articles summarize a rich and extensive body of psychiatric literature on constructing a basic and necessary therapeutic frame for the sound conduct of an impossible task known as psychotherapy.[4,5]

Finally, Dr. Kroll critiques studies of precursor boundary violations that eventually lead to therapist sexual misconduct.[6–13] He states:

> There is relatively little recognition of the diversity of schools of therapy and value differences in the psychotherapy field. Because most writing about boundary crossings and violations seems to end up in discussions about therapists' sexual misconduct, there is an inference that the boundary violator is in reality a sex abuser-in-waiting.

With this statement, as elsewhere, Dr. Kroll sets up straw men to knock down. It is true that, in medicine in general and in psychiatry in particular, studying the pathologic to arrive at an understanding of "normality" has a long, fruitful tradition. Like forensic pathologists, forensic psychiatrists have much to offer the clinician. This is especially true in studying boundary violations in sexual misconduct cases. Of course, boundary violations do not "inexorably" lead to sexual misconduct. Most boundary crossings and violations are detected early by therapists and turned to the clinical benefit of the patient.

Dr. Kroll concludes his article with these polemical remarks:

> Although it is helpful to examine specific cases in which harm has been done and to try to anticipate warning signs that therapy is going awry in the direction of exploitation of a patient, the recent practice of constructing highly specific guidelines that reflect one set of preferred methods and values does a disservice to the majority of those in the healing professions and to their patients. The influence of these boundary guidelines and of the cynical risk-management warning that it is more important to avoid the semblance of wrongdoing than to struggle to do the right thing can be subjected to a public debate about efficacy and values in psychotherapy.

For every harm done by therapists who have misconstrued boundary guidelines as inflexible boundary standards, I submit that many more therapists have harmed patients, themselves, and the mental health professions by not following generally accepted boundary guidelines.

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