Boundary Violations: A Culture-Bound Syndrome

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A backlash against the self-actualizing psychotherapy movements of the 1960s and 1970s in concert with recent concerns about professional sexual misconduct has led some forensic psychiatrists to redefine many routine components of therapy as boundary behaviors. This concern has been followed by the development of conservative guidelines for how therapists should conduct themselves at the newly-defined boundary crossings so as to avoid "violations." The slippery-slope argument that seemingly innocuous boundary crossings may lead inexorably to professional sexual misconduct has lent an urgency and legitimacy to the guideline enterprise, obscuring the perspective that the newly postulated boundaries do not represent the consensus of practitioners in the field. Otherwise highly controversial claims about what is ethical and proper behavior in psychotherapy gain a mantle of incontrovertibility when linked to predictions that ignoring published boundary guidelines will result in damage to patient and litigation against therapist. In this article, three widely advanced boundary guidelines are examined (therapist neutrality, therapist anonymity, and stable fee policy) for coherence and relevance to the richly diverse practice of psychotherapy.

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A recent convergence of tort law cases, state regulatory statutes, professional licensing board decisions, and journal articles have expanded the notion of boundary violations in psychotherapy and have defined it with a moralistic and legalistic certitude that would have been unthinkable 30 or 40 years ago. Because there is scant agreement regarding optimal models of psychotherapy, it seems imperative that there should be room for legitimate divergences of opinion about what psychotherapy boundaries are and what constitutes proper "boundary behavior" between therapist and patient.

From a reading of the recent literature on this topic, one would scarcely guess that discussions of boundary choices in psychotherapy are matters of cultural values, not of facts. Conspicuously absent in the presentation of guidelines for maintaining proper boundaries in psychotherapy is some acknowledgment that the specifics of such guidelines are culture bound, changing every decade or so as new perspectives, economic arrangements, and sociopolitical and risk-management pressures impinge on and shape the practice and, more covertly, the theory of psychotherapy.

The term "boundary," as used in psychotherapy, designates a broad metaphorical construct borrowed from ordinary language, given special and technical meaning, and then reintroduced into ordinary language, with the technical meaning now permanently attached to the everyday meaning. Examples of other terms similarly transmuted from the psychotherapy domain into the vernacular include defenses and defensiveness, the unconscious (as a noun), and denial. Most articles championing a particular set of boundary-violation guidelines do not bother to define boundaries. Gabbard[1] is an exception. He defines boundaries as the " 'edge' or limit of appropriate behavior by the psychiatrist in a clinical setting." Boundaries are both fluid and highly bound by convention. They define, as well as follow, rules of social behavior and engagement but are adaptable to circumstances and context. For example, the convention by which we define comfortable physical space between strangers in a social situation is altered when

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the two strangers abut each other in a crowded subway car.

Boundary constructs are one important component of the psychotherapy process. As stated by Gutheil and Gabbard,[2] "[T]he establishment of clear boundaries is designed to create an atmosphere of safety and predictability within which treatment can thrive." The question remains, of course, of how and where boundaries should be defined and located within the larger domain of psychotherapy. The present article enters into this controversy with the viewpoint that the boundary concept has been unnecessarily and unhelpfully expanded. As one example of an alternative construct, because every interaction between patient and therapist serves an ongoing process of redefining their relationship, many verbal choices routinely selected by a therapist can be construed as relationship oriented as well as, or rather than, as boundary oriented.

Boundary conventions appear to be culturally shaped. In recent years, some workers in the psychotherapy field have redefined the generally accepted social conventions defining verbal and physical behavior between therapist and patient as boundary-related issues rather than, as once was the case, as limit-setting processes or specific therapeutic techniques. Although this redefinition may have salutary effects in clarifying some highly problematic behaviors (e.g., sexual activity with patients), other categories newly considered to be boundary behaviors (e.g., fee arrangements, policy regarding self-disclosure) do not necessarily gain in theoretical coherence or ethical analysis by such recategorization.

Boundary Crossings

Much of the recent psychological literature on boundaries has been preoccupied with sexual misconduct in psychotherapy.[3–5] The fallout of this absorption with policing sexual misconduct, however, has resulted in excessively restrictive readings of what constitutes the range of proper boundary behavior and, reciprocally, in an expanded notion of suspect "boundary crossings" on the part of the therapist that are now interpreted as unwise, problematic, or even reckless therapeutic actions. There has also been a tendency to incorporate more and more of the ordinary give-and-take of therapeutic processes into a special class of boundary processes.

If the orthodox domain of permissible therapeutic behavior is confined either to silent listening or to verbal interactions that encourage the patient to say more or that clarify, point out patterns in, or interpret the patient's fantasies and behaviors, then, by definition, words of encouragement, any sort of self-disclosure, and any nonverbal act, such as offering a tissue to a crying patient or giving medication samples to an indigent patient (or, indeed, prescribing medication) constitute boundary crossings, as defined by Gutheil and Gabbard.[7] To be sure, Gutheil and Gabbard,[2] in a more recent article, are not suggesting that boundary crossings are necessarily, in and of themselves, examples of poor therapeutic technique or harmful to patients. Nevertheless, boundary crossings are identified, along with boundary violations, as the two categories comprising the domain of "boundary transgressions."

If this is so, what are the distinctions between crossings and violations? According to Gutheil and Gabbard,[2] and Gabbard,[1] a boundary crossing is a benign transgression, the ultimate effect of which is positive, because it advances the therapy constructively (offering condolences to a grieving patient is an example of a benign boundary crossing), whereas boundary violations are, by definition, a harmful crossing or transgression. The problem, even if one goes along with these particular definitions for the moment, is that the scope of the context by which to judge appropriate technique is so broad and the time frame by which to judge positive versus harmful "ultimate effect" is so vague, that the evaluation of most common boundary crossings is confounded by the very subjectivity and theoretical stance of the person doing the judging.

My point of disagreement with Gutheil and Gabbard and others is that a wide range of therapeutic actions, integral to the very process of many forms of psychotherapy, become boundary crossings only if one agrees that they represent behaviors at the boundary rather than deliberately chosen techniques that come under other (nonboundary) considerations. For example, Tarachow[8] discusses gratification of the patient's neurotically driven wishes, not as a boundary issue but under the conceptual umbrella of determining which aspects of the transference should be maintained by the therapist as "real" and which as "as-if." It is not that offering a tissue or a medication sample to a patient are insignificant actions or have no psychodynamic meanings worth examining, if one follows a psychodynamic model. It is that they only become boundary-crossing behaviors

under some very peculiar and restrictive definitions of boundaries in therapy. Furthermore, defining a boundary crossing as a form of boundary transgression, however benign, sets up a restrictive notion of standard of care by which therapists would have to defend their benign and technically appropriate therapeutic behaviors.

It must be emphasized that this discussion on boundary crossings is not referring to guidelines prohibiting overt sexual behaviors between therapist and patient, nor does it dismiss the important role of boundary considerations in all therapeutic relationships. Rather, the focus is on the broad range of choices in routine interactions between therapist and patient that are now labeled pejoratively as boundary crossings, because they either could presumably lead to sexual transgressions or because they are postulated *a priori*, and in the absence of empirical evidence other than instructive anecdotal reports, to be harmful to the patient's health and welfare.

Much of the literature on sexual misconduct between therapist and patient engages in detailed discussion about antecedent attitudes and behaviors, now redefined as boundary crossings, on the part of the therapist that may lead, directly or indirectly, to the commission of sexual acts between the two parties.[9,10] According to Simon, "It is well to remember that the road to sexual misconduct is strewn with boundary violations that have been committed even by well-trained and previously competent therapists" (Ref. 11, p 92). This progression from innocent and kindly, but overly personal, acts of the therapist to the full transgression of sexual prohibitions in therapy is presented as a compelling argument against the therapist's behaving in ways that appear to depart from the path of professional neutrality and anonymity.

Although it appears obvious that overt sexual behaviors would of necessity be preceded by a series of seductive maneuvers some of which may initially come under the guise of thoughtful concern, one cannot work the logic backward and say that an attitude of thoughtful concern necessarily leads to sexual misconduct. Thus Gabbard,[12] in referring to his series of therapy cases of psychiatrists who have been involved in sexual misconduct with patients, states: "In the vast majority of cases, a gradual erosion of boundaries precedes an overt sexual relationship." This is undoubtedly true. The more relevant statistic, however, would be the number of therapists whose practices involve routine boundary crossings, but who are never exploitative of their patients. But precisely by working backward from behaviors that putatively lead to sexual activity between therapist and patient, restrictive guidelines have been elaborated for avoiding those initial treacherous steps onto the slippery slope that, at first sight, appear to be far removed from sexual boundary violations.

It is as if any psychotherapy that does not end in sexual transgression is a success and, conversely, that failures in psychotherapy are unimportant so long as a sexual boundary violation did not occur. The anecdotes of sexual transgression are dramatic and compelling. Ignored and undramatic in these discussions, or dismissed as straw horses, are the many examples that could be given of therapeutic failure resulting from excessive scrupulosity and rigid adherence to strict boundaries that do not allow therapeutic engagement and examples of therapeutic progress triggered by a patient's sense of a shared humanity with a supportive therapist. This is elaborated on by Martin Williams, who points out that a significant feature of the humanistic psychotherapy model has been devoted "not to maintaining but to tearing down the boundaries between therapist and patient" (Ref. 13, p 241).

Dalenburg,[14] in her fairly large study of trauma patients' responses to their perceptions of their therapists' countertransference behaviors, found that psychotherapy patients were much more distressed by therapists' unexplained negative or outright rejecting responses to the patients' requests for therapist self-disclosure or nonsexual touching than by their therapists' limited self-disclosures, agreement to nonsexual touching, or forthright explanations (including countertransference disclosure) for their decisions. Although Dalenburg's findings can be criticized as having the problems inherent in all patient self-report studies, and even more so because transference is involved, nevertheless, the detailed and thoughtful responses of the patients in this study provide a useful counterbalance to the many examples of negative outcomes to boundary crossings reported in the boundary-guideline literature.

The slippery-slope argument suffers from the illogic of all *post hoc* arguments. What is the base rate of therapists who show thoughtful concern from which sexual misconduct does not arise? What percentage of therapists and patients who address each other on a first-name basis never proceed to sexual

congress or to any form of exploitation of the patient? If there are valid reasons for a therapist to avoid certain boundary crossings, it must be, first of all, because these are indeed boundary crossings, rather than reflections that the boundaries may have been artificially set too restrictively, and, second, that the boundary crossings, in and of themselves, constitute poor therapeutic technique or are harmful to the patient, not because they resemble social behaviors allegedly on the road to seduction. Further, not all categories of poor technique fall under the classification of boundary crossings. Untimely or poorly worded interpretations or answering the telephone during a psychotherapy session are examples of poor therapeutic technique rather than boundary crossings.

What are the boundary crossings and violations to which we refer? In a series of articles, Simon[11,15] and Simon and Williams[16] have proposed a table of Boundary Guidelines for Psychotherapy, as follows: maintain relative patient neutrality; foster psychological separateness of patient; protect confidentiality; obtain informed consent for treatments and procedures; interact verbally with patients; ensure no previous, current, or future personal relationship with the patient; minimize physical contact; preserve relative anonymity of therapist; establish a stable fee policy; provide a consistent, private, and professional setting; and define time and length of sessions.

These 11 guidelines include some relatively fundamental points with which few therapists would take much issue, such as protecting the confidentiality and fostering psychological separateness (assumedly from the therapist) of the patient. However, several other guidelines are very problematic in terms of employing a particularly conservative model of psychotherapy and of endorsing a set of values for the process of psychotherapy that appears to be at odds with the reality of how psychotherapy is practiced across a broad range of clinical settings. The question must be raised of what gives this particular guideline list its credence, wisdom, and mandate. Do the guidelines reflect a common consensus rather than a perspective in which litigation and risk management concerns have come to outweigh clinical judgment across a broad range of psychotherapies? What is the evidence that observing these latest guidelines for boundary behavior leads to a more successful therapeutic outcome?

It is in posing these questions that historical and cultural perspectives come into consideration. Many of Simon's guidelines, and similar ones advanced by Gutheil and Gabbard, reflect a blending of a classic psychodynamic model with very recent concerns shaped by dramatic sociopolitical and legal pressures of the past two decades. The guidelines promulgated in the 1990s appear to represent a conservative backlash against the more liberal and self-actualizing psychotherapy movements of the 1960s and 1970s, such as Gestalt therapy, the family-therapy orientations of Jay Haley and Carl Whittaker, the rational-emotive therapy of Albert Ellis, and the more directive schools of cognitive-behavioral therapy. Historical consideration of the broad scope of psychotherapy theory and practice makes it very clear that recent definitions of boundary crossings and violations reflect one particular set of culture-bound therapy rules that have no special claim to canonical interpretation and acceptance.

From Simon's list of 11 boundary guidelines, I have selected three for purposes of examination. Indeed, any of the 11 guidelines would benefit from a close philosophical and clinical analysis, but space constraints militate against such an undertaking. The three guidelines were not selected because they might be more susceptible to critical examination, but rather because they are representative of the assumptions and reasoning that underlie the entire set. The three guidelines are: (1) maintain relative therapist neutrality; (2) preserve relative anonymity of therapist; and (3) establish a stable fee policy.

Maintain Relative Therapist Neutrality

In view of ongoing research and debates about what constitutes the therapeutic elements of psychotherapy,[17–19] the guideline to maintain relative therapist neutrality is particularly puzzling. Since most experts on the efficacy of psychotherapy seem to agree that nonspecific factors, such as sympathetic attention and conveyance of affirmation and hope, rather than use of specific techniques or interpretations, are critically important agents of positive change in psychotherapy, it is difficult to understand the recommendation for a neutral rather than a supportive approach as the standard for psychotherapy. Leaving aside the historical evidence, as noted by Gabbard[1] and Gutheil and Gabbard,[7] that the founding fathers and mothers of intensive psychotherapy honored this precept as much in the breach

as in the observance, the guideline of neutrality runs a greater risk of poor therapy in the form of lack of engagement and therapeutic rigidity than in overengagement and boundary violation. This is especially true in much cross-cultural work in which a neutral stance would be perceived as distinctly unhelpful and even hostile.

Ralph Greenson[20] narrates, in his chapter on transference, a supervision case in which an analyst-in-training maintained neutrality so rigidly that he was unable to respond in human terms to his patient's distress about her baby's serious illness. The patient quits therapy the next session, with the comment that the therapist, who still failed to inquire about the baby's health, was sicker than she was. Although arguing from examples always carries the unfairness of selecting cases to demonstrate a point, this was a clinical situation in which neutrality was carried out to the letter of the law but to the detriment of the process of therapy and, of course, the patient.

Who wants a neutral therapist? What does it even mean for a therapist to be neutral? Psychotherapy is a value-driven activity, and silence and neutrality connote aloofness and indifference. It is reasonable to assume that patients want and deserve support, encouragement, and respect for their endeavors and those Rogerian virtues of positive regard and accurate empathy, as described at length by Jerome Frank.[21] More recently, Martin Seligman,[22–25] in a series of editorial articles that he wrote as president of the American Psychological Association and in an earlier book, has commented on instilling hope and building buffering strengths as two very important, but often ignored, deeper strategies of effective psychotherapy. Seligman writes:

> I believe that it is a common strategy among almost all competent psychotherapists to help their patients build a large variety of strengths, rather than just deliver specific damage-healing techniques. Among the strengths built in psychotherapy are courage, interpersonal skill, rationality, insight, optimism, honesty, perseverance, realism, capacity for pleasure, putting troubles into perspective, future mindedness and finding purpose.[19]

When my patient finally returns to college and produces some "A" papers in a graduate creative writing class, should I not congratulate her and extol her courage and determination? Of course, such behavior on my part runs the risk that, if she is unsuccessful in her next endeavor, she will be doubly mortified and feel that I care for her only when she is achieving and not when she fails. But I will run that risk, because the risk of failure is itself lessened when one is encouraged and supported in one's attempts.

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. If there is legitimate concern in particular cases that a therapist is moving toward exploitation of a patient, sexual or otherwise, then there are well-elaborated typologies and profile descriptions of the abusive and exploitative therapist to use in identifying vulnerable and unethical therapists and in assessing rehabilitation potential without casting suspicion on all therapists.[1,4,8,9,11,26,27]

Preserve Relative Anonymity of Therapist

This guideline may make sense when one is in an office building in private practice treating patients with borderline personality disorder. However, it ignores the very rich and controversial discussions about the role of self-disclosure in psychotherapy.[28,29] The modifier "relative" in the anonymity guideline is not especially helpful. Even in a private practice, anonymity is, in fact, a myth, as acknowledged by Gabbard[1] and earlier by Tarachow.[8] 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.[11]

Is it helpful or hurtful of the therapeutic process if I tell my patient where I went on my last trip when he or she asks? Is there an invariant answer? Always helpful? Always hurtful? Most important, will it necessarily lead to further and further revelations, until I am confessing my sexual fantasies to my patient? A literal reading of many writers on this subject would have you think so. Gutheil and Gabbard[7] state unequivo-

cally: "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 is that not all therapists are in agreement that a therapist's self-disclosure is indeed, let alone always, a boundary crossing. It appears that self-disclosure is viewed as a regular therapeutic technique by some psychotherapists and as a boundary crossing by other therapists. In a survey of psychologists' self-reported rates of boundary-related activities, Pope *et al.*[30] found that almost 70 percent of respondents used self-disclosure as a therapeutic technique ranging from "sometimes" to "very often." If such a very common practice is considered a boundary crossing, perhaps it is time to rethink our ideas about where and how to identify boundaries in psychotherapy.

I was on the staff of New York Hospital-Westchester Division in the early 1970s. Faculty housing was on the grounds of the hospital. Patients not only saw my spouse and children, but also had an opportunity to observe and judge how I interacted with my family. The medical staff at many state hospitals, until recently, also lived on the grounds of their hospitals. The first generation of psychoanalysts had offices attached to their urban apartments. Patients knew what their analysts ate for lunch and dinner. There are still psychiatrists and psychologists who practice in home offices. Does this constitute a boundary violation? Is patient care compromised by these practices?

One of the five cases discussed at length in Waldinger's and Gunderson's[31] excellent book on psychotherapy with borderline patients narrates the treatment of a young woman who is stranded in a snowstorm for several hours in the evening at her therapist's home office. The therapist is surprised to find that his children have invited the young woman to stay for dinner. The dinner goes off quite well, but the therapist is dismayed about the anticipated effects of this event on treatment. He "felt it likely that the work would be totally disrupted or hopelessly stymied by such a gross breach of traditional boundaries of a therapeutic relationship." However, the opposite occurred. The patient, in subsequent sessions, noted how mundane the therapist's house seemed, how much his children were like other children, how ordinary the chicken was that his wife cooked for dinner. All that the patient had yearned for was not so special after all. The therapist notes, "This seemed to have a calming effect on her, and she subsequently spent less and less time badgering me for personal information."

There are sufficient boundary violations in this vignette, and more so in the entire case history, to justify a dozen lawsuits if one were to adopt the approach that boundary crossings and nonsexual boundary violations are often as damaging to patients as actual sexual misconduct. But there would be no difficulty in matching, case for case, examples of successful outcome linked to extending the boundary behaviors well beyond the restrictive guidelines discussed earlier in the article with examples of poor outcome attributable to poor boundary behaviors. Anecdotes are illustrative and instructive but have been selected to demonstrate a point and therefore cannot be used in place of empirical evidence.

Establish a Stable Fee Policy

This is another guideline that is locked into a limited model of private-practice psychotherapy with middle-class and affluent patients, unless what is meant is that a therapist ought not to change fee arrangements capriciously. But then, this is an unnecessary admonition, for a therapist ought never to behave capriciously. The conventional wisdom that the patient does not appreciate or benefit from cost-free or discounted psychotherapy appears to rationalize a contemporary acquisitive attitude to goods, services, and generosity. Freud not only did not charge the Wolf Man, but lent him money. Especially today, with restricted insurance coverage for psychotherapy and high hourly fees relative to some patients' $7- to $12-an-hour salaries, a flexible fee structure must be open to negotiation and renegotiation between patient and therapist. Gabbard suggests that the therapist who does not charge a fee acts from a neurotic need to be liked by the patient.[1,10] Although the term "charity" has unkind connotations of condescension and noblesse oblige, there may be something to be said in favor of devoting a certain percentage of one's practice time to providing treatment at no charge.

Here is what Carl Rogers[32] in 1942 had to say in a section entitled "Does Charging a Fee Affect Coun-

seling?" He begins by stating, "There are many counseling situations in which fees are entirely inappropriate." Not naive to the therapeutic complications arising in regard to not charging or, alternatively, to setting an unrealistic fee, Rogers proceeds with a discussion of the therapeutic value to charging a fee. He concludes, however, by suggesting that "the point should very definitely be made that non-directive counseling can be carried on whether or not fees are charged. In this respect, it differs from orthodox psychoanalysis, in which a fee is almost a necessary part of treatment."

I invoke Carl Rogers' words, not to argue from authority, but to make the more basic point that there are thoughtful and legitimate differences, even among experts, in point of view about the proper place of fees in psychotherapy. Rogers' position, operating from an insight-oriented but not transference-based model, is that the patient is expected to work hard in therapy and that the matter of fees may be relatively incidental.

Recent changes in the manner in which we practice our profession make it all the more clear that there can be no universal guidelines about fees. What makes sense and is good procedure for one group of practitioners is not good for all groups. Furthermore, the marketplace ethics of American health care has made it too easy and convenient to dump our relatively impecunious patients in the middle of a course of psychotherapy when the health maintenance organization (HMO) or third-party insurer refuses to approve an additional 10 sessions. What has happened to our professional standards, to our commitment to patients?

The guideline about a stable fee policy requires that the psychiatrist be paid in money only. Barter is not permissible. Gutheil and Gabbard[7] agree that barter should be avoided, but imply by their wording that their concerns are primarily about risk management: "Barter is confusing and probably ill-advised today." Simon and Williams,[16] in a discussion of how to maintain boundaries in a rural practice, illustrate the importance of following their fee guideline with the following case vignette.

A psychiatrist practices in an island community dependent on farming. She is the only psychiatrist on the island. Her fee is $100 per hour. The psychiatrist treats a woman with postpartum depression whose condition improves with antidepressants and bimonthly supportive psychotherapy. After eight weeks of treatment, however, the patient informs the psychiatrist that she can no longer afford to pay for treatment. The patient's husband, the only poultry farmer on the island, offers to cultivate melons on the psychiatrist's land and pay his wife's psychiatry fee from his share of the income from the produce. The psychiatrist counters with an offer that the farmer provide 5,000 chicks for the psychiatrist's husband to get into the poultry business. The farmer reluctantly agrees but is resentful because he is setting up a business competitor on the island. When poultry prices increase later, the psychiatrist's husband makes windfall profits, to the detriment of the farmer's profits. A year later, the patient relapses into depression but does not feel that she can return to the psychiatrist for care.

Is this a fair argument against providing treatment at no charge, fee reduction, or bartering? It sounds like a tale of greed and inhumanity. Simon and Williams[16] state, "Psychiatrists may ethically elect not to continue to treat a non-emergency patient who is unable to pay for treatment." It may be legally permissible to discontinue treatment under such circumstances, but discontinuing treatment may itself create a crisis or emergency situation. It is the assumption of universal applicability of the authors' particular value system that is most troublesome.

I submit that discontinuing treatment in many contexts is a subversion of all that we have been taught about medical responsibility, but my value system holds no special persuasive power over others. There is no question that some patients will take advantage of cost-free treatment or reduced fees and that countertransference problems can easily play into injudicious fee arrangements. But these situations should be determined on a case-by-case basis, as stressed by Gutheil and Gabbard,[7] and not by fiat. It may also be the case that the realities of practice under managed care do not permit care to be provided at no charge, reduced fees according to the therapist's discretion, or bartering. But we should not mistake decisions based on market pressures for decisions based on ethical or therapeutic considerations. Incidentally, a 1996 survey of a sample of American Psychiatric Association psychiatrists found that, nationally, psychiatrists discount fees for 35 percent of their patients.[33]

Did the patient have a choice of practitioners in this case? Abandoning the patient until a suicide attempt defines a state of emergency seems ethically

unacceptable. Under these circumstances, common humanity should dictate continuation of care of the woman with postpartum depression and acceptance of the reasonable and even generous barter offer of the husband.

Simon and Williams[16] also state that "treating the patient for free might feel like the right human response but would likely be destructive to any current or ongoing therapy." What is the evidence for this assertion that it should be generalized into an almost universal truth about fees and then incorporated into a canonical list of guidelines for proper therapy? There are many respectable examples in which care is responsibly given at no charge.[34] 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. I submit that fee arrangements have no place in a list of practice guidelines for psychotherapists.

Discussion

Recent promulgation of guidelines for proper treatment boundaries reflects a narrow vision of psychotherapy that is colored extensively by concern about malpractice suits. The guidelines are offered as if there were near-universal agreement about which psychotherapy model among many is the proper model and as if the values inherent in the present guidelines were not narrowly culture bound and, in this case, expedient reactions to a variety of new social and political pressures. Many decisions about therapeutic technique and practice that might reflect a particular school of psychotherapy or a particular value set of the therapist—for example, whether to have a patient address the therapist by first name or whether to charge a fee in all cases—have been redefined as boundary issues and therefore subjected to boundary-crossing scrutiny. These therapeutic choices are not inherently boundary issues until labeled as such. Therapeutic actions such as role modeling, direct suggestions ("It is not a good idea to shoplift"), and setting of fees are part of a larger therapeutic process and need not be construed as boundary behaviors.

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. The term "violation" is itself a particularly malignant term that conjures up images of sexual violation, even when the alleged boundary violation has nothing to do with sexual misconduct. Furthermore, the attribution of many so-called boundary crossings to countertransference problems is a subtle, or not so subtle, way of criticizing the nonsexual boundary crosser or violator. This occurs even though the therapist who is deemed a boundary crosser may not agree in the slightest with the existence of such a boundary as defined by a recent guideline, let alone that there has been a boundary crossing or violation.

Because discussions accompanying the boundary guidelines frequently assume that countertransference phenomena lie behind most sexual boundary transgressions, the remedy most often proposed is to instruct the practitioner about transference and countertransference. There are two problems with placing transference at the center of sexual-boundary considerations. First of all, not every model of psychotherapy acknowledges the importance of or, indeed, the existence of transference. For example, cognitive and behavioral techniques either largely ignore transference or do not base successful outcome in therapy on the working through of a transference relationship. Second, why frame the boundary problem as one of knowledge (ignorance of transference and countertransference) rather than as one of morality or volition?

In several studies, sexual misconduct is not correlated with type or level of training or school of thought of the practitioner.[35,36] If anything, surveys of psychiatrists, psychologists, and social workers have consistently found higher rates of sexual offenses against patients in therapists who are better trained, have undergone personal therapy, and are considered more successful in their field.[27] In most cases, the practitioner knows what is right and wrong, but chooses the wrong, and along the way develops a secondary rationalization to justify unethical behavior. Although further or remedial education about the psychodynamics of transference can do no harm, other than to assume that the problem lies in this arena, it may be more helpful to pay attention to deficits in the transgressor's moral reasoning. If the sexual misconduct problem is indeed char-

acterological, then it is unlikely that technical rather than ethical training will be effective.[37]

Although all this transference talk may have relevance to those practitioners who have committed or are on the verge of committing sexual misconduct, it misses the point about the overly broad guidelines proposed for the general conduct of psychotherapy. Boundary behaviors, even boundary crossings, and sexual misconduct are related but separate problems. If the slippery-slope argument is discounted as a valid reason to accept guidelines that are at serious variance with how most professionals practice psychotherapy, then the legitimacy of one group's rules about fees, neutrality, and self-disclosure is seriously diminished.

As a result of redefining therapeutic processes of many sorts as boundary crossings and the subsequent recommendations of specific guidelines, the positive value of boundary concepts and the use of boundary awareness and discussion within the therapeutic situation are often lost. Boundary considerations are most helpful when they are presented as broad ethical considerations, most usually in terms of "do no harm" and its more modern counterparts, "do not exploit the patient" and "be aware of the power differential between therapist and patient."[38] 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.

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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. Kroll 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. Kroll's selective citation of my work.

Dr. Kroll 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. Kroll:

> 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 I[2] 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. Kroll 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. Kroll'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. Kroll'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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