Commentary: The Therapeutic Process and Professional Boundary Guidelines

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Dr. Kroll's article on boundary violations raises a number of important issues about the current state of our knowledge concerning the complex and subtle interpersonal processes that are central in psychotherapy. I agree with Dr. Kroll's observations that although serious boundary violations in professional relationships are probably always preceded by some forms of boundary crossings, this does not necessarily confirm the slippery-slope hypothesis that subtle boundary crossings inevitably lead to serious boundary violations. But the controversy about what constitutes boundary crossings and their impact on the treatment process evokes important questions about our understanding of the therapeutic process and the conditions that facilitate therapeutic change.

Dr. Kroll's primary point is that the current formulations about boundary crossings flow primarily from one theoretical orientation—a psychodynamic orientation, based on assumptions that are not necessarily consistent with other forms of psychotherapy. The contemporary emphasis on intersubjectivity and the value of therapists' sharing with their patients aspects of the therapists' personal experiences, both within and external to treatment, for example, is a very different model from classic psychodynamic psychotherapy.

Different forms of psychotherapy operate with very different assumptions about the mutative forces in the treatment process. In some approaches, the essence of the treatment process occurs in the deprivation of gratification and in the therapist's maintaining relative neutrality and anonymity to facilitate the emergence of the transference and eventually the transference neurosis. Although psychoanalysis allows for deviations from classic technique in the introduction of "parameters," these deviations in the treatment process are acceptable only if clinical formulations justify their use. Generally, however, these deviations are viewed as potentially compromising the treatment process. Other forms of treatment, in contrast, stress the importance of maintaining, as fully as possible, an egalitarian orientation in the therapeutic relationship and the communication of concern about, and investment in, the patient. Although the various orientations in psychotherapy all agree on the destructive consequences of boundary violations, particularly those of a sexual relationship between therapist and patient, they have very different views about what constitutes boundary crossings and their therapeutic consequences. Differences in the definition of boundary crossings and the understanding of their impact on the treatment process derive from fundamental differences in what each of these orientations consider to be an effective therapeutic process and how various factors are mutative and result in constructive therapeutic change.

These extensive differences in fundamental assumptions about the nature of the therapeutic process are unlikely to be resolved in debate and discussion. Rather, these differences must be addressed by systematic research that identifies and understands the mechanisms through which dimensions of the treatment process contribute to, or interfere with, constructive therapeutic change. Despite this urgent need for systematic investigation of the factors that lead to therapeutic change, much of contemporary psychotherapy research, at least in the United States,

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is focused on the comparison of the relative efficacy of various forms of manual-directed brief treatment in reducing a focal symptom. Attempts to identify empirically validated treatments usually result in comparative-treatment trials that focus on the techniques and tactics of brief treatments designed to reduce symptoms, and little attention is directed toward understanding the therapeutic process and the factors that contribute to therapeutic change.

The results of the investigations to establish empirically validated treatments generally indicate that active treatments are usually more effective than no treatment at all (waiting-list control groups) and more effective than imprecisely defined control groups such as treatment that is generally available in the community (treatment as usual, or TAU). More rigorous research designs that compare active treatments usually result in few significant differences between active treatments—what Luborsky and colleagues[1] have called, after the creature in *Alice in Wonderland*, the Dodo-bird effect—that is, all have won and therefore all should have prizes. Thus, research for identifying empirically validated treatments usually contributes little to our understanding of the implications of the major differences in therapeutic assumptions that Dr. Kroll raises in his consideration of boundary crossings. Without further knowledge and data about the nature of the mutative forces in the psychotherapeutic process, our discussions about boundary crossings and their potential impact on the treatment process are influenced by our assumptions and biases about what we think constitutes an effective therapeutic process.

Although I agree with Dr. Kroll's emphasis on the unique quality of each therapeutic dyad and the need for the therapist to be flexible in considering what might facilitate therapeutic progress with a particular patient, there are alternatives to the formulations that Dr. Kroll presents in his discussion, particularly the three issues he addresses in his consideration of boundary crossings: therapist neutrality, therapist anonymity, and the need to establish a stable fee schedule.

Dr. Kroll links neutrality with silence, a lack of engagement, and therapeutic rigidity, compared with the therapist's offering support, encouragement, and respect, which Dr. Kroll attributes to the attitude of positive regard first articulated by Carl Rogers.[2] But I think it is in Roger's articulation of the necessary and sufficient conditions for therapeutic change that we can find possible resolution for some of these differences in therapeutic technique that Dr. Kroll so dramatically polarizes. Having been a psychology predoctoral intern in the mid-1950s with Dr. Rogers at the Counseling Center of the University of Chicago, I understand that the primary focus of client-centered therapy is the ability of the therapist to assume the patient's internal frame of reference. Rogers stressed that the primary task of the therapist is to articulate the patient's experiential field through interventions that he classified as reflections, clarifications, and, on occasion, even interpretations. If, as Rogers suggests, one maintains a focus on articulating the patient's phenomenal world, then it is possible to be both neutral and sympathetic, to be separate from the patient and still provide affirmation and hope.

Dr. Kroll discusses an example (cited by Greenson) of a therapist who, in a grotesque attempt to maintain neutrality, makes no mention of the serious illness of his patient's infant.[3] An alternative to the dilemma posed by Dr. Kroll of either ignoring this issue in treatment and being unresponsive to the patient's concerns and preoccupations or offering support and reassurance is for the therapist to capture in words the affective field of the patient and to reflect to the patient her intense concerns about the well-being of her child. By giving voice to the patient's predominant concerns, preoccupations, and feelings through reflections and clarifications, the therapist is able to maintain neutrality and still be responsive to the patient through sharing the patient's phenomenal field. The therapeutic task is to maintain focus on and to articulate the patient's internal frame of reference, rather than to make judgments about the patient from an external perspective—to give voice to the patient's thoughts and feelings.

The same would be true for another example provided by Dr. Kroll about the academic success of one of his patients. As Dr. Kroll notes, commenting on and praising his patient for her current success raises the possibility that the therapist may subsequently also have to comment, from an external perspective, on her failures as well. As I understand Rogers' emphasis on assuming the patient's internal frame of reference, what Rogers called "catching the edge of awareness," one might comment to Dr. Kroll's patient about her sense of joy and pride in her accomplishments, as well as on another possible occasion, commenting about her feeling disheartened or de-

pressed about her failure. In addition to providing an empathic response through these reflections of the patient's phenomenal field, such an approach provides patients with experiences of feeling understood and that their feelings and thoughts are understandable, as well as encouraging patients to reflect more fully on their feelings and experiences. Neutrality is not an alternative to empathy; rather, neutrality is maintained through an empathic nonjudgmental focus on articulating patients' thoughts and feelings—their experiential field.

Anonymity of the therapist in the treatment process, also raised by Dr. Kroll, is a complex issue, because it is often not clear whether it is the patient who wants to know details of the life of the therapist or whether the therapist, for any number of reasons, feels a need to share aspects of his or her life with the patient. Often, therapists feel a desire to share aspects of their experiences with the patient to reassure the patient that he or she is not the only one who has experienced such difficulties or to provide a role model for the patient of how one might cope with such difficulties. Again, I think the issue is not whether to maintain anonymity, but to maintain the focus on the phenomenal field of the patient as the central therapeutic task. Thus, it is important to put into words the patient's curiosity about aspects of the therapist and to ask the patient, as well as oneself, to consider what the patient really wants to know and why.

Conversely, it is important for the therapist to consider why he or she feels the need to share specific information with a patient at a particular moment in the treatment process. Frequently, the therapist's desire to reveal aspects of him or herself to the patient is a response of the therapist to sensing the emergence of some important transferential issue that has been dormant in the treatment process. It is often more productive for the therapist to reflect on the therapist's wish to share aspects of his or her life with the patient and the implication of this wish for understanding aspects of the patient and of the treatment process.

Of course, patients learn important things about the therapist in the treatment sessions, as well as through various networks in the community. What is important, however, is not necessarily what the patient thinks he or she has learned about the therapist, but the meaning that this information has for the patient. Thus, once again, the focus is on the patient's phenomenal field and the patient's desires and curiosity as well as the meanings the patient attributes to the information he or she has gleaned about the therapist and the implications that this meaning has for understanding important aspects of the patient's life.

The third topic that Dr. Kroll addresses in his consideration of boundary crossings is the issue of establishing a stable fee schedule. As Dr. Kroll implies, the need to establish a stable fee structure has become an increasingly important problem because of the large number of patients whose psychotherapy is supported, at least partly, by third-party payments, either by a health maintenance organization (HMO) or an insurance contract. Although it is important to discuss these matters of fees and the general forms of psychotherapy before beginning treatment, the current vicissitudes of managed care programs create conditions in which patients' coverage can change unexpectedly during the treatment process. As Dr. Kroll recommends, the therapist should be flexible and should maintain commitment to the patient.

However, it is also important for the therapist to place the subject of fees in the broader context of other issues of the treatment frame, such as the time and length of the therapy sessions and the policy about changed or canceled appointments. The management of these problems is partly contingent on the nature of the patient's life and therapist's clinical practice. Therefore, it is difficult to define precisely how a particular patient and therapist should deal with requests to alter aspects of the therapeutic frame once they have been established, including the fee. But again, it is important to focus on the implications of these requests as part of the treatment process and to consider the implications that these requests and the potential response to them have for the issues currently active in the therapeutic relationship.

Requests for change in fee structure and the time or length of treatment sessions have to be responded to with appreciation of the reality of the life context of both patient and therapist, but also with the awareness of the conscious and unconscious meanings that these requests and the responses to them can have for the patient and the therapist. Requests can be motivated by the patient's wish to manipulate or test the therapist and can be experienced in a similar fashion by the therapist, even though there may be realistic components to these requests. The therapist's positive response to the patient's requests can

be experienced consciously and unconsciously by the patient as indulgence and seduction or as caring and sympathetic understanding; and the therapist's negative response can be experienced as rejection, inflexibility, and rigidity, or as a constructive setting of limits. It is as important for the therapist to consider the potential unconscious meanings that the request to change aspects of the treatment frame have for the patient, as it is for the therapist to find constructive ways to respond to these requests.

Clearly, my responses to Dr. Kroll's comments and suggestions are determined by my assumptions about the treatment process and what I consider to be the factors in the treatment process that contribute to therapeutic change. In addition, there are no universal answers to the various boundary crossings discussed by Dr. Kroll, because these problems vary from patient to patient and from therapist to therapist, and their meanings vary, even at different times in the treatment process. We will be able to begin to address these problems more effectively only when we have understood more fully the various dimensions of the treatment process and their contributions to therapeutic change. Although we can debate the subjects of efficacy and values in psychotherapy, these debates would be greatly enhanced by systematic research that begins to specify the dimensions of the therapeutic process that facilitate, or impede, sustained therapeutic progress.

References

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