Boundary crossings: Guard against inappropriate contact

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Woman claims improper contact during treatment

Fairfax County (VA) Circuit Court

A 23-year-old woman who received treatment from a psychiatrist for approximately 2½ years claimed that he sexually abused her during that time. She alleged that the inappropriate sexual relationship included holding, hugging, kissing, fondling, and watching pornography. The patient claimed that the relationship led to emotional distress and caused her to attempt suicide.

The psychiatrist admitted that a sexual relationship occurred but contended that the patient suffered no harm.

> **A $400,000 verdict was returned**

Did inappropriate contact cause agoraphobia, anorexia?

Suffolk County (MA) Superior Court

A patient in her 20s had a history of emotional problems and sexual assaults against her. A psychiatrist treated her for obsessive-compulsive disorder for 4 years. He acknowledged giving the patient stuffed animals, cards, and letters and visiting her home several times when she was unable to go to his office. During sessions he touched her hand for comfort and hugged her. The patient claimed they had regular sexual contact.

The patient alleged that the psychiatrist was negligent for engaging in inappropriate sexual conduct, which she claims caused ongoing emotional distress. She claimed she was unable to work and suffered from agoraphobia, intimate relationships difficulties, and anorexia as a result of his actions. The psychiatrist denied any inappropriate sexual conduct.

The psychiatrist's license was suspended indefinitely, but the suspension was stayed under an agreement that he attend medical education courses.

> **A $750,000 settlement was reached**

Dr. Grant's observations

Although most physicians would agree that sexual relations with a patient are inappropriate,[1] the fact that cases continue to occur suggests a need to emphasize treatment boundaries. Establishing clear boundaries in the doctor-patient relationship creates an atmosphere of safety and predictability that allows treatment to thrive.[2]

Boundary problems are one of the most frequent reasons for malpractice actions against mental health providers.[3] Although much of the literature discusses boundary violations during psychotherapy, issues may arise in all treatment settings, including psychopharmacologic management.

One-half of all psychiatrists will treat at least 1 victim of physician sexual mis-

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Clinical Point

28% of physicians disciplined for sex-related offenses were psychiatrists, the most represented specialty in the study

Box

Boundary violations: Code of ethics guide conduct

The American Medical Association's *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* states: "A psychiatrist shall not gratify his or her own needs by exploiting the patient. The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor-patient relationship, and thus upon the well-being of the patient. These requirements become particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.

"Further, the necessary intensity of the treatment relationship may tend to activate sexual and other needs and fantasies on the part of both patient and psychiatrist, while weakening the objectivity necessary for control. Additionally the inherent inequality in the doctor-patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient is unethical."

Source: Reference 9

conduct during their careers.[4] One study[5] examining sex-related offenses committed by U.S. physicians in all specialties found:

- The number of physicians disciplined for sex-related offenses increased each year from 1989 to 1996.
- 22% of disciplined physicians had sexual intercourse with patients, 15% had sexual contact or touching, 37% committed other sexual abuse that did not fit in either of these 2 categories, and 25% involved nonpatients.
- 28% of disciplined physicians were psychiatrists, the most represented specialty in the study.

In a 1986 survey of psychiatrists, 7% of male and 3% of female clinicians reported having sexual contact with their patients.[6] A 1988 survey of fourth-year psychiatry residents found that 1% of respondents acknowledged having sexual relations with a patient.[7] In a 1992 study, 9% of physicians across specialties reported engaging in sexual contact with 1 or more current or former patients.[8] In that study, 19% of female physicians and 40% of male physicians reported that they did not think physician-patient sexual misconduct was always harmful to patients.[8] These views and behaviors are in violation of medical codes of ethics (***Box***).[9]

How misconduct harms patients

Trust is essential to establishing a secure therapeutic relationship. Boundary violations may result in missed diagnoses, inappropriate treatment, and/or worsened psychiatric symptoms. Patients might develop complex posttraumatic stress disorder, depression, anxiety, dissociation, sexual dysfunction, somatoform disorders, eating disorders, sleep disorders, or substance use disorders.[4] They could lose faith in their treatment providers, have difficulties expressing anger, feel guilty, develop poor self-concept, experience a loss of confidence, and develop problems establishing trusting relationships.[4] For these reasons, clinicians can be sued for negligent treatment and sexual misconduct.[10]

Boundary violations

Although sexual activities with patients are clear boundary violations, what about the second case when the therapist gave the patient stuffed animals and cards and hugged her? Progressive boundary violations often precede and accompany sexual misconduct.[10]

Five risk factors have been associated with therapist boundary violations:[3]

- life crises—effects of aging, career disappointments, unfulfilled hopes, or marital conflicts

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Table

How to maintain integrity of the treatment process

Maintain relative therapist neutrality
Foster psychological separateness of the patient
Protect confidentiality
Obtain informed consent for treatments and procedures
Interact verbally with patients
Ensure that you do not have any previous, current, or future personal relationships with the patient
Minimize physical contact
Preserve the therapist's relative anonymity
Establish a stable fee policy
Provide a consistent, private, and professional setting
Define the time and length of sessions

Source: Reference 10

Clinical Point

When examining 'minor' boundary issues, ask yourself if the action is for your benefit rather than to advance the patient's therapy

- transitions—job changes or job loss
- medical illness
- arrogance—the belief that a boundary violation couldn't happen to him or her and not recognizing the need for consultation
- common stress points with the patient

Although the list is not exhaustive, these factors may be associated with a psychiatrist turning to the patient for solace, gratification, or excitement.

Drawing boundary lines

Not all boundary issues are the same, and Gutheil et al[2] suggest 2 categories:

- **Boundary crossings**—a benign variant where the deviation may advance therapy in a constructive way that does not harm the patient, such as discussion of countertransference.
- **Boundary violations**—the transgression harms or exploits the patient.

Although some boundary issues may appear benign, even theoretically harmless boundary crossings can be misrepresented or misconstrued by the patient.[11] Also, boundary transgressions that do not involve erotic touch might harm the treatment process and the patient.[2]

When examining "minor" boundary issues that may seem innocuous, ask yourself if the action is for your benefit rather than to advance the patient's therapy. Also, determine if the intervention is part of a series of progressive boundary violations. If the answer to either question is "yes," desist immediately and take corrective action.[10]

The psychiatrist has a professional code of ethics to follow and can be held responsible for failing to set or adhere to boundaries.[11] If a patient initiates a boundary violation, you must refuse and then explore the patient's underlying psychological issues, perhaps aided by consultation with a peer or mentor (***Table***). Repeated patient demands to breach boundaries requires prompt consultation to determine if you can continue treating the patient or if you should transfer the patient to another clinician. Document the patient's demands to breach boundaries and your actions when seeking consultation.[3]

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