Current PSYCHIATRY

Psychiatrist/patient boundaries: When it's OK to stretch the line

Some boundary crossings are therapeutic, but beware the 'slippery slope' to violations

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Dr. M is facing financial challenges with his fledgling private practice and begins consulting at a weight loss clinic to supplement his income. He finds himself attracted to Ms. Y, a weight-loss patient he is treating. They seem to click interpersonally, and he extends his office visits with her. Ms. Y clearly enjoys this extra attention, and Dr. M begins including personal disclosures in his conversations with her.

In his residency training, Dr. M was taught never to date a current or former patient, but he views this situation as different. Ms. Y is seeing him only for weight loss, and he rationalizes that he is providing her with medical care, not "psychiatric" care. On 2 occasions he gives her a limited quantity of benzodiazepines for mild anxiety, which he considers a transitory stress-related condition and not an "official" DSM-IV-TR disorder.

Eventually, Dr. M asks Ms. Y to dinner and she accepts. After they begin dating, he decides to transfer her to another clinic physician "just to be safe."

Although many psychiatrists assume that psychiatrist/patient boundaries are well defined by ethical and legal standards, boundary issues are a complex and controversial aspect of clinical practice. Psychoanalysts initially defined psychiatrist/patient boundaries as a way of structuring the unique and intimate relationship that evolves during analysis.[1,2] The introduction of other therapeutic techniques and changes in health care funding have combined to make psychiatrist/patient boundaries far more complex.

continued

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Psychiatrist/ patient boundaries

Clinical Point

Boundaries prevent the therapeutic relationship from transforming into caretaking of the psychiatrist by the patient

Box

Psychiatrist/patient boundaries: What the APA says

All physicians are required to practice in accordance with the American Medical Association's *Principles of Medical Ethics.* Because these guidelines can be difficult to interpret for psychiatry, the American Psychiatric Association provides further guidance with *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry.* The following excerpts from annotations to the first 2 principles spell out the basic concepts underlying appropriate psychiatrist/patient boundaries:

'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.

'The requirement that the physician conduct himself/herself with propriety in his or her profession and in all the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification. 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 6

Boundary violations are about exploitation. Both the American Medical Association (AMA) and the Canadian Medical Association warn members to "scrupulously avoid using the physician/patient relationship to gratify their own emotional, financial, and sexual needs."[3]

Boundaries represent the edge of appropriate behavior and serve 2 important purposes:

- They separate the therapeutic relationship from social, sexual, romantic, and business relationships and from relationships that transform into caretaking of the psychiatrist by the patient.
- They structure the professional relationship in ways that maintain the identity and roles of the patient and the professional.[4]

Psychiatry's unique dilemmas

As are all physicians, psychiatrists are governed by the 9 biomedical ethics set forth in the AMA's *Principles of Medical Ethics*. The American Psychiatric Association (APA), however, acknowledges that psychiatry has a "broader set of moral and ethical problems and dilemmas" that are unique to and magnified by the mental health setting.[5] The APA has adopted 39 standards in addition to those set forth by the AMA. The first standard captures the unique responsibilities inherent in the psychiatrist/patient relationship: A psychiatrist shall not gratify his or her own needs by exploiting the patient (***Box***).[6]

Sexual contact with patients is inherently harmful to patients, always unethical, and usually illegal.[7] The rate of sexual misconduct among psychiatrists is unknown. National Practitioner Data Bank information is not available to the general public.[8] Based on literature reviews and data from individual states[9,10] and government agencies,[11] an estimated 6% to 10% of psychiatrists have had inappropriate sexual relations with patients.[12] Estimates of sexual misconduct by psychiatrists:

- increase if misconduct is based on patient complaints
- decrease if self-reports are used
- decrease even further if based on official investigations.[4]

American psychoanalyst Frieda Fromm-Reichman reportedly offered her colleagues

a not-so-humorous admonition: "Don't have sex with your patients; you will only disappoint them."[4]

Nonsexual boundary violations—such as accepting gifts, entering into business arrangements, or trying to influence a patient's political or religious beliefs or sexual orientation—occur more frequently than sexual misconduct.[12] Although the impact of nonsexual violations generally is less serious, any relationship that coexists with the therapeutic relationship has the potential to impair your judgment and contaminate your ability to focus exclusively on your patient's well-being.[13] Be cautious about any decision that could affect the treatment relationship.[14]

Triangle relationships. Originally, this term referred to the patient/therapist/psychiatrist triad. The term now has a broader meaning that includes:

- encroachments into care by managed care companies and government regulatory agencies
- interactions with the patient's family members
- providing psychiatric care in nontraditional settings such as schools or prisons
- serving as an expert witness.[15]

The framework of trust once considered a core feature of the psychiatrist/patient relationship is being undermined by a funding system that demands efficiency and economy.[16] Recognizing that some settings sacrifice patients' clinical needs to the interests of the organization, the APA's *Guidelines for Ethical Practice in Organized Settings* stipulate that the psychiatrist must "strive to resolve these conflicts in a manner that is likely to be of greatest benefit to the patient" by (for example):

- informing a patient of financial incentives or penalties that limit your ability to provide appropriate treatment
- not withholding information the patient could use to make informed treatment decisions, including treatment options not provided by you.[6]

Psychiatrists who doubt that the system—such as a mental health clinic, hospital, or managed care contract provider or reviewer—upholds the standard of acceptable care have the "ethical responsibility" to improve the system.[6]

Another change in mental health care attempts to limit psychiatrists to "medication management" so that less expensive professionals can provide adjunctive therapies. The treating psychiatrist bears some responsibility, however, for the appropriateness of the patient's therapeutic options.[6] According to Reid,[17] psychiatrists are responsible for knowing something about the care, treatment style, credentials, and even ethics of those with whom they share treatment or to whom they refer patients.

The American Academy of Child and Adolescent Psychiatry (AACAP) *Code of Ethics* addresses the unique challenges encountered when a patient's opinions differ from those of parents and other authority figures, such as school staff. The AACAP standards consistently direct the psychiatrist to keep the child's interest primary, explaining that "the child and adolescent psychiatrist may be called upon to participate in attempts to control or change the behavior of children or adolescents…[but] the child and adolescent psychiatrist will avoid acting solely as an agent of the parents, guardians, or agencies."[18]

Another triangle can occur when a treating psychiatrist serves as an expert witness or other evaluator for forensic or disability purposes. The American Academy of Psychiatry and the Law (AAPL) recommends that psychiatrists avoid acting as expert witnesses for their patients or performing patient evaluations for legal purposes.[19] While recognizing that certain situations may require a psychiatrist to serve a dual role, the AAPL stresses that sensitivity to differences between clinical and legal obligations remains important.

Avoid serving as an expert witness for your patient. The intrusion of another role into the doctor/patient relationship can alter the treatment process and permanently color future interactions. Likewise, treating an individual whom you previously evaluated for forensic purposes raises similar concerns, including the possibility of a mercenary motivation. Even when no such

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Clinical Point

Avoid acting as an expert witness for your patients or evaluating them for legal purposes

Adverse Events with an Incidence ≥1% in Intramuscular Trials—The following treatment-emergent adverse events were reported at an incidence of ≥1% with intramuscular olanzapine for injection (2.5-10 mg/injection) and at incidence greater than placebo in short-term, placebo-controlled trials in agitated patients with schizophrenia or bipolar mania: ***Body as a Whole***—asthenia; ***Cardiovascular***—hypotension, postural hypotension; ***Nervous System***—somnolence, dizziness, tremor.

Dose Dependency of Adverse Events in Short-Term, Placebo-Controlled Trials—Extrapyramidal Symptoms—In an acute-phase controlled clinical trial in schizophrenia, there was no significant difference in ratings scales incidence between any dose of oral olanzapine (5±2.5, 10±2.5, or 15±2.5 mg/d) and placebo for parkinsonism (Simpson-Angus Scale total score >3) or akathisia (Barnes Akathisia global score ≥2). In the same trial, only akathisia events (spontaneously reported COSTART terms akathisia and hyperkinesia) showed a statistically significantly greater adverse events incidence with the 2 higher doses of olanzapine than with placebo. The incidence of patients reporting any extrapyramidal event was significantly greater than placebo only with the highest dose of oral olanzapine (15±2.5 mg/d). In controlled clinical trials of intramuscular olanzapine for injection, there were no statistically significant differences from placebo in occurrence of any treatment-emergent extrapyramidal symptoms, assessed by either rating scales incidence or spontaneously reported adverse events.

Dystonia, Class Effect—Dystonia symptoms (prolonged abnormal contractions of muscle groups) may occur in susceptible individuals during the first few days of treatment. While these symptoms can occur at low doses, the frequency and severity are greater with high potency and at higher doses of first-generation antipsychotics. In general, an elevated risk of acute dystonia may be observed in males and younger age groups receiving antipsychotics; however, dystonic events have been reported infrequently (<1%) with olanzapine.

Other Adverse Events—Dose-relatedness of adverse events was assessed using data from this same clinical trial involving 3 fixed oral dosage ranges (5±2.5, 10±2.5, or 15±2.5 mg/d) compared with placebo. The following treatment-emergent events showed a statistically significant trend: asthenia, dry mouth, nausea, somnolence, tremor.

In an 8-week, randomized, double-blind study in patients with schizophrenia, schizophreniform disorder, or schizoaffective disorder comparing fixed doses of 10, 20, and 40 mg/d, statistically significant differences were seen between doses for the following: baseline to endpoint weight gain, 10 vs 40 mg/d; incidence of treatment-emergent prolactin elevations >24.2 ng/mL (female) or >18.77 ng/mL (male), 10 vs 40 mg/d and 20 vs 40 mg/d; fatigue, 10 vs 40 mg/d and 20 vs 40 mg/d; and dizziness, 20 vs 40 mg/d.

Vital Sign Changes—Oral olanzapine was associated with orthostatic hypotension and tachycardia in clinical trials. Intramuscular olanzapine for injection was associated with bradycardia, hypotension, and tachycardia in clinical trials (*see* PRECAUTIONS).

Laboratory Changes—Olanzapine is associated with asymptomatic increases in SGPT, SGOT, and GGT and with increases in serum prolactin and CPK (*see* PRECAUTIONS). Asymptomatic elevation of eosinophils was reported in 0.3% of olanzapine patients in premarketing trials. There was no indication of a risk of clinically significant neutropenia associated with olanzapine in the premarketing database.

ECG Changes—Analyses of pooled placebo-controlled trials revealed no statistically significant olanzapine/placebo differences in incidence of potentially important changes in ECG parameters, including QT, QTc, and PR intervals. Olanzapine was associated with a mean increase in heart rate of 2.4 BPM compared to no change among placebo patients.

Other Adverse Events Observed During Clinical Trials—The following treatment-emergent events were reported with oral olanzapine at multiple doses ≥1 mg/d in clinical trials (8661 patients, 4165 patient-years of exposure). This list may not include events previously listed elsewhere in labeling, those events for which a drug cause was remote, those terms which were so general as to be uninformative, and those events reported only once or twice which did not have a substantial probability of being acutely life-threatening. *Frequent* events occurred in ≥1/100 patients; *infrequent* events occurred in 1/100 to 1/1000 patients; *rare* events occurred in <1/1000 patients. ***Body as a Whole***—*Frequent:* dental pain, flu syndrome; *Infrequent:* abdomen enlarged, chills, face edema, intentional injury, malaise, moniliasis, neck pain, neck rigidity, pelvic pain, photosensitivity reaction, suicide attempt; *Rare:* chills and fever, hangover effect, sudden death. ***Cardiovascular***—*Frequent:* hypotension; *Infrequent:* atrial fibrillation, bradycardia, cerebrovascular accident, congestive heart failure, heart arrest, hemorrhage, migraine, pallor, palpitation, vasodilatation, ventricular extrasystoles; *Rare:* arteritis, heart failure, pulmonary embolus. ***Digestive***—*Frequent:* flatulence, increased salivation, thirst; *Infrequent:* dysphagia, esophagitis, fecal impaction, fecal incontinence, gastritis, gastroenteritis, gingivitis, hepatitis, melena, mouth ulceration, nausea and vomiting, oral moniliasis, periodontal abscess, rectal hemorrhage, stomatitis, tongue edema, tooth caries; *Rare:* aphthous stomatitis, enteritis, eructation, esophageal ulcer, glossitis, ileus, intestinal obstruction, liver fatty deposit, tongue discoloration. ***Endocrine***—*Infrequent:* diabetes mellitus; *Rare:* diabetic acidosis, goiter. ***Hemic and Lymphatic***—*Infrequent:* anemia, cyanosis, leukocytosis, leukopenia, lymphadenopathy, thrombocytopenia; *Rare:* normocytic anemia, thrombocythemia. ***Metabolic and Nutritional***—*Infrequent:* acidosis, alkaline phosphatase increased, bilirubinemia, dehydration, hypercholesteremia, hyperglycemia, hyperlipemia, hyperuricemia, hypoglycemia, hypokalemia, hyponatremia, lower extremity edema, upper extremity edema; *Rare:* gout, hyperkalemia, hypernatremia, hypoproteinemia, ketosis, water intoxication. ***Musculoskeletal***—*Frequent:* joint stiffness, twitching; *Infrequent:* arthritis, arthrosis, leg cramps, myasthenia; *Rare:* bone pain, bursitis, myopathy, osteoporosis, rheumatoid arthritis. ***Nervous System***—*Frequent:* abnormal dreams, amnesia, delusions, emotional lability, euphoria, manic reaction, paresthesia, schizophrenic reaction; *Infrequent:* akinesia, alcohol misuse, antisocial reaction, ataxia, CNS stimulation, cogwheel rigidity, delirium, dementia, depersonalization, dysarthria, facial paralysis, hypesthesia, hypokinesia, hypotonia, incoordination, libido decreased, libido increased, obsessive compulsive symptoms, phobias, somatization, stimulant misuse, stupor, stuttering, tardive dyskinesia, vertigo, withdrawal syndrome; *Rare:* circumoral paresthesia, coma, encephalopathy, neuralgia, neuropathy, nystagmus, paralysis, subarachnoid hemorrhage, tobacco misuse. ***Respiratory***—*Frequent:* dyspnea; *Infrequent:* apnea, asthma, epistaxis, hemoptysis, hyperventilation, hypoxia, laryngitis, voice alteration; *Rare:* atelectasis, hiccup, hypoventilation, lung edema, stridor. ***Skin and Appendages***—*Frequent:* sweating; *Infrequent:* alopecia, contact dermatitis, dry skin, eczema, maculopapular rash, pruritus, seborrhea, skin discoloration, skin ulcer, urticaria, vesiculobullous rash; *Rare:* hirsutism, pustular rash. ***Special Senses***—*Frequent:* conjunctivitis; *Infrequent:* abnormality of accommodation, blepharitis, cataract, deafness, diplopia, dry eyes, ear pain, eye hemorrhage, eye inflammation, eye pain, ocular muscle abnormality, taste perversion, tinnitus; *Rare:* corneal lesion, glaucoma, keratoconjunctivitis, macular hypopigmentation, miosis, mydriasis, pigment deposits lens. ***Urogenital***—*Frequent:* vaginitis*; *Infrequent:* abnormal ejaculation*, amenorrhea*, breast pain, cystitis, decreased menstruation*, dysuria, female lactation*, glycosuria, gynecomastia, hematuria, impotence*, increased menstruation*, menorrhagia*, metrorrhagia*, polyuria, premenstrual syndrome*, pyuria, urinary frequency, urinary retention, urinary urgency, urination impaired, uterine fibroids enlarged*, vaginal hemorrhage*; *Rare:* albuminuria, breast enlargement, mastitis, oliguria. (*Adjusted for gender.)

The following treatment-emergent events were reported with intramuscular olanzapine for injection at one or more doses ≥2.5 mg/injection in clinical trials (722 patients). This list may not include events previously listed elsewhere in labeling, those events for which a drug cause was remote, those terms which were so general as to be uninformative, and those events reported only once or twice which did not have a substantial probability of being acutely life-threatening. ***Body as a Whole***—*Frequent:* injection site pain; *Infrequent:* abdominal pain, fever. ***Cardiovascular***—*Infrequent:* AV block, heart block, syncope. ***Digestive***—*Infrequent:* diarrhea, nausea. ***Hemic and Lymphatic***—*Infrequent:* anemia. ***Metabolic and Nutritional***—*Infrequent:* creatine phosphokinase increased, dehydration, hyperkalemia. ***Musculoskeletal***—*Infrequent:* twitching. ***Nervous System***—*Infrequent:* abnormal gait, akathisia, articulation impairment, confusion, emotional lability. ***Skin and Appendages***—*Infrequent:* sweating.

Postintroduction Reports—Reported since market introduction and temporally (not necessarily causally) related to olanzapine therapy: allergic reaction (e.g., anaphylactoid reaction, angioedema, pruritus or urticaria), diabetic coma, jaundice, neutropenia, pancreatitis, priapism, rhabdomyolysis, and venous thromboembolic events (including pulmonary embolism and deep venous thrombosis). Random cholesterol levels of ≥240 mg/dL and random triglyceride levels of ≥1000 mg/dL have been reported.

DRUG ABUSE AND DEPENDENCE: Olanzapine is not a controlled substance.

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motivation exists, these situations can create the appearance that you have conscripted a vulnerable individual into your practice.

Emerging trends

Crossings vs violations. Efforts to distinguish when an action is unethical or illegal have led some to differentiate boundary crossings from boundary violations. Unfortunately, the 2 terms continue to be used synonymously, which confuses rather than clarifies the issue:

- Boundary crossings are aimed at enhancing the therapist's treatment efforts—such as a hug instead of a handshake at the end of a particularly difficult treatment session.
- Boundary violations are invariably harmful and unethical because they serve the therapist's needs rather than the patient's needs or the therapeutic process.[20]

Rather than trying to differentiate between crossings and violations or to determine under what circumstances changing boundaries is acceptable, Sheets[21] conceptualizes a boundary not as a line to cross, but as a continuum of behavior. Under-involvement at one end, over-involvement at the other, and a "zone of helpfulness" is in the middle.

Glass uses a Venn diagram to illustrate that although most boundary crossings probably fall within the realm of ethical practice, gray areas alert therapists that they are approaching a violation (***Figure***).[20] Five factors have been found to increase psychiatrists' vulnerability to boundary violations (***Table 1***).[22]

CASE CONTINUED

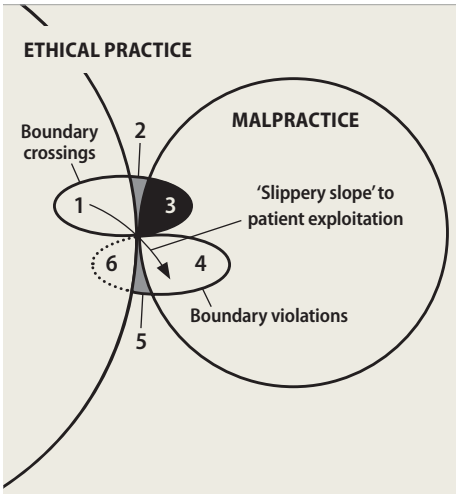
Board investigation

Dr. M's relationship with Ms. Y grows intense, and he becomes increasingly concerned about her "clinginess." After several months, Dr. M feels emotionally suffocated and ends the relationship. Despondent and suicidal, she seeks treatment in the local emergency room. Ms. Y tells the ER psychiatrist about her relationship with Dr. M and that she cannot go on without him in her life. The ER psychiatrist refers her to another psychiatrist for outpatient care, and, with Ms. Y's permission, files a complaint about Dr. M with the state medical board and the district branch ethics committee.

The state medical board investigates Dr. M. He is contrite about his actions and their effect on Ms. Y. The state board refers Dr. M to an impaired physician's program. He is required to attend a boundary violations course and undergo 1 year of practice supervision by a local psychia-

Figure

Beware the 'gray areas' between boundary crossings, violations



1. **Boundary crossings**—nonprogressive departures from established treatments that are aimed at adapting treatment to an individual patient
2. **Boundary crossing 'gray area'**—minor modifications in schedules, fee structure, using first names
3. **Aggregated boundary crossings**—numerous crossings that in combination begin to border on malpractice
4. **Boundary violation**—clear violations of professional ethics (sexual contact, dual relationships)
5. **Boundary violations 'gray area'**—therapist-initiated actions that depart from established practice
6. **Pseudo-boundary violations**—therapist action is within the realm of ethical practice, but patient perceives it as a violation (such as Tarasoff warning, mandated reporting)

Source: Glass L. The gray areas of boundary crossings and violations. *Am J Psychother* 2003;57(4):429-44. Republished with permission of the Association for the Advancement of Psychotherapy

trist. Several years later, Dr. M is doing well in his practice and has had no further complaints lodged against him.

Boundaries vs relationships. Using boundaries as a metaphor for maintaining the separation of therapist and patient was intended to serve the analytic process and to protect the patient's welfare.[2] Clearly, certain boundaries—such as sexual contact between psychiatrist and patient—must remain sacrosanct. Yet certain practices avoided in analysis may be appropriate for other therapeutic interventions. For example, whereas psychoanalysis has strict prohibitions against seeing patients anywhere except in the office, cognitive-behavioral therapists may find it useful to conduct sessions in public, or—under carefully arranged circumstances—even in a patient's home. Other examples include accompanying a patient with agoraphobia to a public gathering or dining with a patient with anorexia.

Exercise caution when you decide to alter traditional boundaries. Even minor crossings that are not likely to progress to violations have the potential to contaminate the therapeutic relationship and place the psychiatrist on a "slippery slope" to patient exploitation.[22,23] Some boundary issues are ambiguous, and extenuating circumstances can create a context that temporarily stretches a boundary beyond its normal limits,[24] especially in small communities and rural settings where patients and treating psychiatrists are likely to know and encounter each other in social settings.[25] Our recommendations for avoiding boundary violations appear in ***Table 2 (page 62)***.

Except in clear cases of malfeasance, determining whether or not you have crossed a boundary is not a straightforward decision based on a single theoretical perspective or absolute standard.[26] Regardless of whether a given boundary's edge is well defined, 2 things are clear:

- unlike patients, psychiatrists have a professional code to honor[27]

continued

Table 1

Boundary violations: Factors that increase your vulnerability

Life crises—effects of aging, career disappointments, unfulfilled hopes, or marital conflicts
Transitions—job changes or job loss
Medical illness
Arrogance—the belief that a boundary violation couldn't happen to you and not recognizing the need for consultation
Stress points shared by the patient

Source: Reference 22

Clinical Point

'Gray areas' such as using first names or minor changes in fee structure can alert therapists that they are approaching a violation

Psychiatrist/ patient boundaries

Clinical Point

Be careful when altering traditional boundaries because even minor crossings can contaminate the therapeutic relationship

Table 2

Simple steps help avoid boundary violations

Dos
Know your state's statutes regarding medical ethics
Stay abreast of the American Psychiatric Association's *Principles of Medical Ethics*
Consult with colleagues
Be aware of your weaknesses
Avoid 'slippery slopes'
Use objective documentation
Build a satisfying personal life
Don'ts
Don't foster dependency
Don't use patients for your own gratification
Don't engage in extra-therapeutic contacts
Avoid physical contact
Don't accept gifts or services

- harm is determined by the meaning of the behavior to the patient and not the psychiatrist's intentions.[4]

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Related Resources

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Bottom Line

Avoid boundary violations by staying abreast of APA ethics guidelines and your state's ethics statutes, being aware of your own weaknesses, consulting with colleagues, and using objective documentation. Don't foster dependence, use patients for your own gratification, have extra-therapeutic contact, or accept gifts or services from patients.