When Boundaries Blur

The Challenge of Delivering Mental Health Care in Rural Clinics

Maurice Sprenger, MD, Enrico Camara, MD, and Penny Jeffers, RN, MSN, CS, CNAA

Clinicians practicing in rural community-based outpatient clinics may be at greater risk for violating provider-patient boundaries than their urban counterparts. Here's why—and what we can do to help them set appropriate limits.

Over the past decade, in order to improve access to care, the VHA has undergone a reorganization that redirects care from inpatient to outpatient facilities. This initiative created hundreds of community-based outpatient clinics (CBOCs). By January 31, 2003, the VA was operating a total of 681 CBOCs, with plans to open more in fiscal years 2004 and 2005.[1] About 40% of these, or approximately 270 CBOCs, are located in rural areas.

The delivery of health care in general, and mental health care in particular, can vary tremendously from urban to rural settings. Rural communities are more likely than urban settings to be characterized by geographic isolation, inadequate employment opportunities, lack of public transportation, higher levels of mental illness (especially substance abuse), and higher suicide rates.[2] And, typically, they provide limited access to such services as mental health care, substance abuse treatment, and suicide counseling services and resources.[3] These circumstances can challenge clinicians' ability to maintain customary provider-patient boundaries and traditional ethical practices.

In this article, we present three case histories that illustrate some of the ways in which mental health care professionals working in VA CBOCs or other rural, clinical settings can develop boundary problems. We discuss the reasons boundary regulation may be more difficult in rural settings, describe the outcomes of these specific cases, and propose ways for supervisors to respond to boundary violation and to prevent or at least minimize its occurrence.

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Dr. Sprenger is the clinical manager of the VISN 7 mental health service line; a clinical associate professor of psychiatry and behavioral sciences in the department of psychiatry at Emory University School of Medicine, Atlanta, GA; and an associate clinical professor in the department of psychiatry at the University of Hawaii John A. Burns School of Medicine (UH JABSOM), Honolulu. **Dr. Camara** is the director of the Traditional, Alternative and Complementary Healing Program at the VA Pacific Islands Health Care System, Honolulu, HI and a clinical professor in the department of psychiatry at the UH JABSOM. **Ms. Jeffers** is the associate director for nursing services at the Tuscaloosa VA Medical Center, Tuscaloosa, AL; a nurse executive for the VISN 7 mental health service line; and an adjunct clinical assistant professor in the Capstone College of Nursing at the University of Alabama, Tuscaloosa.

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TRAINING AND PRACTICE DISPARITIES

The chief purpose of a therapeutic boundary is to create an environment that fosters a therapeutic alliance while avoiding the exploitation of a patient. Central to the understanding of boundaries is the realization that there are expectations and interactions that are considered either appropriate or inappropriate within a therapeutic relationship. When professional training and practice occur in entirely different types of settings, however, the practitioner may be unable to integrate the learned boundary regulations into the unfamiliar physical and cultural environment.

Most of the nation's mental health care professionals are trained in an urban setting. Failing to prepare these practitioners for boundary maintenance within the context of a rural setting may lead to unintentional violations. The following three cases in which such violations occur highlight specific practice irregularities that should serve as warnings to management that further investigation is warranted.

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CASE 1: EXCESSIVE POLYPHARMACY

Dr. X worked as a full-time psychiatrist for several years in a rural VA CBOC. Patient incident reports cataloged the following problems in his practice: excessive prescription of benzodiazepines (he prescribed 50% of all benzodiazepines for the facility, while his practice accounted for only 1.6% of all patients), prescription of benzodiazepines for patients with active addictions, failure to identify patients with substance abuse histories, repeated patient overdoses with no resultant changes in the treatment plan, large amounts of medications prescribed for patients with histories of overdose, excessive polypharmacy (more than 50% of his patients were taking five or more classes of psychotropic drugs after an initial visit), lack of clinical documentation to support diagnoses—most notably of posttraumatic stress disorder (PTSD)—and prescription practices, the assignment (in compensation and pension examination reports) of global assessment of functioning scores that were much lower than could be supported by medical records, and instances of inappropriate socialization with patients outside of the clinic setting.

In response to feedback provided by his supervisor, Dr. X insisted that his reviewers didn't understand the "unique" characteristics of his patients or share the "special" knowledge he had regarding PTSD and its treatment. He contended that they were ignorant of his newly described diagnosis of "rural PTSD syndrome" and were conspiring to eliminate his position as part of VHA downsizing. He dismissed most of their findings as unimportant and rationalized his practice with long discussions on the molecular basis of psychiatry. He suggested that rural psychiatry required intensive contact with patients including, at times, visits to his home.

An administrative board upheld the findings of the management reviews, and Dr. X was removed from practice and enrolled in a retraining program.

CASE 2: LITTLE PROGRESS; MINIMAL DOCUMENTATION

Dr. Y provided fee-for-service psychiatric counseling to VA clients in another rural CBOC. A review of one of his cases revealed that, in more than two years, the patient had made little, if any, progress and that the psychiatrist kept minimal clinical documentation on the case. In response, Dr. Y questioned these findings and characterized the poor documentation as an attempt to protect the patient's confidentiality. He claimed to have discovered a new treatment for PTSD, which he intended to patent, and described this treatment as 100% effective—provided that patients completed seven or more years of counseling with him. Other patients seen by Dr. Y reported perceiving him as a friend whom they could call or visit at his home. Referrals to this clinician were discontinued.

CASE 3: INAPPROPRIATE INTIMACY

Dr. Z, a psychologist, directed a residential treatment facility located in a rural area. In the course of an administrative review of the work environment, it was discovered that he had had an intimate relationship

with an employee under his supervision, which affected the work environment negatively for other staff. Furthermore, the employee was found to have had inappropriate personal relationships with patients who had stayed at the facility.

In addition, the review board investigation uncovered that Dr. Z was working another full-time job with work hours overlapping his VHA hours. And, in the course of carrying out an unapproved research project, he had shared patient information with other patients. Both Dr. Z and the employee with whom he was intimately involved left the facility to work elsewhere.

ISOLATION AND FAMILIARITY

These three cases demonstrate some of the problems that can arise when mental health care providers practice in relative isolation in rural settings. Many of these problems are rooted in boundary violation, exacerbated perhaps by the challenges of maintaining competency and keeping up-to-date with practice standards while working in an area that's relatively far from educational and administrative resources.

Simon and Williams wrote about how challenging it can be to maintain treatment boundaries in small communities and rural areas.[4] The practitioners in these cases clearly had difficulty maintaining neutrality as evidenced by an inability to set limits with regard to the prescription of controlled substances, the misrepresentation of disability examinations with the apparent aim of enhancing patient compensation, and frequent social interaction with patients outside of the treatment setting.

Boundary regulation may be more difficult in rural settings for a number of reasons—among them, the overlapping and multiple relationships the provider may have with clients and the professional isolation of the therapist as described by Roberts and colleagues.[3] For example, therapists living in large urban areas are unlikely to have unintentional social contacts with their patients. In small towns, however, patient contact outside of the office is apt to be much more common.

Garfinkel and colleagues wrote that a psychiatrist's need to maintain a special connection with clients and the community can greatly interfere with the processes of limit setting and confronting difficult issues.[5] Boundary regulation may be especially difficult for practitioners with such pathologic traits as narcissism, who may have difficulty staying focused on their patients needs without confusing them with their own.[6] All these issues may be more pronounced when there is inadequate peer review and limited supervisory resources, as is often the case in rural settings.

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INSTITUTIONAL TRANSFERENCE

VA practitioners in rural settings also must cope with a greater degree of "institutional transference" than those in larger, urban facilities. In other words, in rural settings, such issues as financial compensation for disability and entitlement to services may be more intense because the practitioners themselves are more likely than their urban counterparts to be viewed as representing the entire agency.[7] The distinction between clinical, administrative, and benefits personnel is less clear in the rural setting than in the large, urban facilities. Moreover, if patients' employment opportunities are limited within the locale, it may cause providers to feel further pressure to distort medical facts in an attempt to ease patients' economic burden. As Case 1 illustrates, this can cause providers to assess patients inaccurately for the purpose of raising disability payments—a practice that is not only unethical but also fraudulent and clearly represents a lack of clinical objectivity based on role confusion.

THREATS TO CONFIDENTIALITY

Confidentiality is always of utmost importance to patient care, but even more so in mental health care—and in rural settings, it is considerably more difficult to provide. In small communities, for example, neighbors and friends can observe whose car is parked at the mental health care provider's office. Add to that the fact that it is often difficult for even the best

Table 1. Helpful hiring and probation activities

- Check references for history of boundary violations
- Interview carefully, using performance-based questions that relate to boundary issues, such as "Tell me about a situation in which a customer or patient wanted you to do something for them that may have been unethical. How did you handle that situation, and what was the outcome?"
- Be mindful of and watch for early warning signs (see Table 2)
- If in doubt, do not hire or retain
- Schedule regular supervisory time with all new employees during probation

Table 2: Early warning signs of possible boundary violation

- Patient complaints
  - — Frequent
  - — Validated
- Staff reports or complaints about the employee
- Evidence of failure to comply with rules and regulations
  - — Misuse of time and leave
  - — Misuse of supplies or equipment
- Lack of regard for well-being of other staff or patients
- Prescribing irregularities
- Distortion of medical facts
- Distortion of caseload
  - — Diagnosing rare cases frequently or excessively
  - — Misdiagnosing cases or making diagnoses without adequate evidence
- Excessive attention to the supervisor or obsequiousness
- Avoidance of supervision
- Excess concern with being "right"
- Poor response to constructive criticism
- Narcissistic personality traits

therapist to avoid talking about challenging or interesting cases—and, in a small town, the connection between the "case" and the actual patient can be made all too easily. Clinicians in rural communities need to be particularly careful not to breach patient confidentiality as occurred in Case 3.

SCREENING, OVERSIGHT, AND TRAINING

Therapist-client and supervisor-employee boundary violations can occur in any setting. We're aware of no data showing that these events occur more frequently in rural than in urban settings. Some characteristics of rural settings, however, certainly make boundary regulation more challenging.

Effective boundary setting, regulation, and maintenance should be addressed through education at the levels of supervisor, clinician, and trainee. All need to understand that boundary violations present risks to safe and effective patient care.

The first step in preventing boundary violation is to identify potential risk during preemployment screening (Table 1). Maintenance of good boundaries requires ongoing supervision, which should include: open and regular discussions of boundary and ethical issues (nonsexual and sexual); reviews of quality management and patient safety data; comparisons of clinician profiles; and opportunities for staff to receive ongoing education in boundary management. Recognition of early warning signs is essential to early intervention and prevention of egregious infractions (Table 2).

For the rural or CBOC staff, use of interactive televideo connections for supervision may increase the effectiveness and regularity of supervisory time. Medical record reviews, comprehensive performance evaluations, and close attention to patient complaints are also essential.

Employee education should aim to improve knowledge, understanding, sensitivity, and clinical skills in the area of boundary regulation. Gorton and colleagues have emphasized the importance of training that includes both didactic and experiential elements delivered regularly during the trainee's development.[8,9] This should be extended to clinicians throughout their employment, with periodic retraining. Special attention to the specific challenges that occur in small and rural communities may be addressed in each of these settings.

Later in the process, managers may be able to minimize harm if they are watchful of their staff and patient populations. It's necessary for them to respond to warning signs with early inquiries and prompt intervention. Timidity is

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Table 3. Wise boundaries*,[10]

- When seeing patients with intense erotic-transference, schedule appointments during high traffic times of day
- Use only dedicated office space for appointments—not restaurants or cars—unless you are a behavioral therapist working with a phobia related to these environments
- Avoid dressing provocatively; wear clothing considered "professional" in your community
- Do not use profanity; some patients regard such language as "verbal rape" and feel assaulted
- Avoid calling the patient by his or her first name too soon
- Avoid barter arrangements—they may be illegal and are ill-advised
- Do not see patients free of charge
- Make clear financial arrangements with patients and follow through on them
- Avoid accepting large gifts from patients
- Small gifts—especially handmade ones—are acceptable, and may represent a step toward health and strength for the patient
- Do not display patients' gifts
- Begin and end sessions on time

*Based on advice provided by Dr. Richard Milone, medical director of St. Vincent's Westchester, Harrison, NY, in: Yasgur, BS. Atmosphere of safety: Boundaries preserve psychotherapeutic process. *Clinical Psychiatry News.* June 2002:38.[10]

dangerous in this arena, and supervisors are wise to follow up on even slight irregularities.

Additionally, such clinician support as building boundary training into peer review meetings, professional community oversight (for example, local peer support groups), and the establishment of boundary guidelines (Table 3)[10] may provide safeguards for staff and patients alike.

Cautious hiring, use of a probation period, and good supervision are important elements in ensuring that appropriate clinician-patient and supervisor-employee boundaries are upheld. The rural setting has unique characteristics that may make it more difficult for clinicians to maintain clear boundaries, but rural as well as urban therapists can improve their boundary skills through education and training. We recommend that VA medical centers, especially those with rural CBOCs, include boundary training at all levels of the organization. ●

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