Maintaining Treatment Boundaries in Small Communities and Rural Areas

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Psychiatrists and other mental health professionals practicing in small communities and rural areas encounter unique situations and customs that may complicate the task of maintaining treatment boundaries. Boundary adjustments are frequently required that do not disturb the psychiatrist-patient relationship. The authors discuss specific boundary problems that arise in maintaining the psychiatrist's neutrality; fostering the psychological separateness of the patient; protecting confidentiality; ensuring that the psychiatrist has no previous, current, or future personal relationship with the patient; preserving anonymity of the psychiatrist; and establishing a stable fee policy. Four vignettes illustrate boundary issues that may be encountered in psychiatric practice in small communities. The authors suggest that applying the rule of abstinence, which states that the therapist must abstain from obtaining personal gratification at the expense of the patient, can help therapists distinguish between boundary issues, crossings, and violations. (*Psychiatric Services* 50:1440–1446, 1999)

Psychiatrists and other therapists who practice in small communities and rural areas frequently encounter a number of unique situations and customs that complicate efforts to establish guidelines for boundary maintenance in the therapist-patient relationship (1). Treatment boundaries are established by mental health professionals to promote trust, a working alliance with the patients, and structure for the therapeutic work (2,3). Variability among psychiatrists and other therapists in setting treatment boundaries is a function of the nature of the patient, the therapist, the treatment, the status of the therapeutic alliance, and the sociocultural milieu.

The concept of treatment boundaries developed primarily from psychoanalysis and outpatient psychodynamic therapy. Ethical principles and legal duties have also defined treatment boundaries. Differences over what constitutes acceptable treatment boundaries go back as far as Freud's disputes with Ferenczi and Reich (4). Although no universally accepted boundary standards exist, broadly based boundary guidelines have received general acceptance among mental health professionals.

This paper examines principles and practices of boundary maintenance in small communities and rural areas. Boundary guidelines—such as therapist neutrality and patient separateness, confidentiality, personal relationships with patients, therapist anonymity and self-disclosure, and fees—are discussed. The guidelines are illustrated by vignettes about situations that may be encountered in psychiatric practice in small and rural communities.

Principles and definitions

A fundamental principle underlying boundary maintenance is the rule of abstinence, which states that the psychiatrist must abstain from obtaining personal gratification at the expense of the patient (4). The psychiatrist's main source of gratification should derive from participating in the therapeutic process and the satisfaction gained in attempting to help the patient. The only material benefit received from the patient should be payment of the professional fee.

It is important that mental health professionals be aware of and work through personal motivations that could interfere with the care and treatment of patients. Unfortunately, boundary violations can be rationalized as being in the best interest of the patient, when conscious or unconscious justification is sought for the mishandling of transference and countertransference or for outright exploitation of the patient. Other principles that form the foundation for treatment boundaries include the therapist's duty to remain neutral, patient autonomy and self-determination, the fiduciary relationship, and respect for human dignity (3).

Boundary issues invariably arise for the patient in relation to treatment boundaries set by the psychiatrist. For example, the patient may complain that the amount of time allotted for treatment sessions is too rigidly maintained. Boundary issues play an essential part in psychotherapeutic work.

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Boundary crossings occur frequently in psychotherapy. For example, the psychiatrist may give a supportive hug to a patient who is distraught over a recent loss. Such boundary crossings are usually benign and recognized by the psychiatrist, and they often can be turned to therapeutic advantage when scrutinized by the psychiatrist and the patient (5).

Boundary violations occur when the psychiatrist's gratification is received primarily from the patient rather than through engagement with the patient in the therapeutic process. Progressive boundary violations may lead to patient exploitation for money or sex or to provide various services for the psychiatrist (6). Understanding the principle of abstinence and the differences between boundary issues, crossings, and violations will help clarify questions that may arise in establishing and maintaining treatment boundaries in small communities and culturally diverse settings.

Treatment boundaries are guidelines for good clinical practice rather than a list of proscribed behaviors (7). However, for every boundary guideline, therapists can always find circumstances where it does not apply. Boundary guidelines should be considered in relation to sociocultural contexts, particularly in small communities and rural settings. Nevertheless, a line can be drawn between boundary flexibility and boundary violations based on the rule of abstinence. Regardless of sociocultural settings, the defining question that the psychiatrist must ask is "Am I making this intervention or taking this action for the benefit of the patient's treatment or for my own personal benefit?"

In metropolitan areas, groups of therapists who know each other and share a theoretical approach often constitute a community in which dual roles may develop. Within these groups, therapists may encounter boundary problems similar to those in small communities and rural areas. For example, boundary dilemmas are known to arise in psychoanalytic societies (personal communication, Strasburger LH, May 1998). The training analyst's position of neutrality toward the analysand could become compromised if the analyst has reporting responsibilities related to the candidate's training (7).

The study of psychiatrists' boundary maintenance in small communities provides useful examples of flexible boundary adjustments that can facilitate treatment. Both in small communities and metropolitan areas, boundary problems usually arise in maintaining the therapist's neutrality; fostering the psychological separateness of the patient; protecting confidentiality; ensuring that no previous, current, or future personal relationship occurs with the patient; preserving the personal anonymity of the therapist; and establishing a stable fee policy. In small communities and rural areas, occasions and circumstances abound that challenge the psychiatrist's ability to maintain flexible but functional treatment boundaries. Nonetheless, broad boundary guidelines exist that find general acceptance among psychiatrists and other mental health professionals, regardless of the type of therapy provided or the practice setting. These guidelines, which are adapted from the work of Simon (3), are listed in the accompanying box.

Patient-therapist boundary guidelines for psychiatrists and other mental health professionals

Maintain relative neutrality
Foster the psychological separateness of the patient
Protect confidentiality
Obtain the patient's informed consent for treatments and procedures
Interact verbally with the patient
Minimize physical contact
Ensure no previous, current, or future personal relationship with the patient
Preserve relative anonymity of the psychiatrist
Establish a stable fee policy
Provide a consistent, private, and professional setting

Therapist neutrality and patient separateness

The psychiatrist's position of relative neutrality establishes a boundary that affirms patient separateness, autonomy, and self-determination. Absolute neutrality is obviously impossible. Maintenance of patient separateness promotes the treatment goal of psychological independence. Although the vignettes that follow are hypothetical, they are distilled from the authors' clinical experiences.

Vignette

A psychiatrist practicing in a small rural community begins treatment of a recently retired military officer, Mr. A, who completed 20 years as a logistic specialist. The patient is experiencing depressive symptoms but only mild functional impairment as he attempts to adjust to civilian life after returning to his hometown. Mr. A expresses his reluctance about seeing a psychiatrist because of the "stigma" but does so at the urging of his parents. His parents are very worried because an older brother committed suicide ten years ago. The psychiatrist has had occasional social contacts with the Mr. A's parents at community functions.

The psychiatrist's fishing partner has a job opening for a supervisor in his warehouse. He is looking for an employee with exactly Mr. A's occupational experience and background. The psychiatrist informs Mr. A about the job and his willingness to contact the friend on his behalf. The "stigma" issue is discussed. Although Mr. A is not initially enthusiastic about the job, he authorizes the psychiatrist to contact the potential employer. The psychiatrist feels that a job similar to Mr. A's military experience will help resolve his depression.

The psychiatrist puts Mr. A in touch with his friend, who hires him immediately. Obtaining a job is con-

sistent with the treatment goal of facilitating Mr. A's civilian adjustment. Mr. A's depression remits after a few months. He feels grateful and obligated to the psychiatrist for finding him a job, but he is uneasy because his boss knows that he has seen a psychiatrist.

Discussion

Although the psychiatrist acts to assist Mr. A's recovery by finding him a job, does the psychiatrist depart from a position of neutrality and compromise the patient's autonomy and self-determination? Mr. A appears to be perfectly capable of finding a job on his own. However, a small town may not have the number and variety of support agencies found in larger cities. Job "head hunters" may not exist. Many individuals living in small communities know one another and rely on personal networking and cooperation in finding jobs. A feeling of friendliness and cooperation generally exists that may also pervade the psychiatrist's practice without necessarily becoming disruptive.

On its face, the psychiatrist's dual role does not appear to be exploitive. It does not seem to cause harm and is probably salutary. However, can the psychiatrist's motives be purely therapeutic since he also performs a favor for a friend who is looking for a suitable employee? Consciously, the psychiatrist's intervention is driven by his wish to help Mr. A adjust to civilian life. The fact that the psychiatrist's friend benefits appears to be a secondary outcome. Purity of motive is seldom to be found in any psychiatric intervention.

In referring Mr. A to his friend for employment, the psychiatrist compromises the confidentiality of the doctor-patient relationship. Mr. A reluctantly gives permission for the psychiatrist to contact his friend. Both he and the psychiatrist acknowledge that revealing his patient status could have possible adverse consequences. Had Mr. A sought employment without the involvement of the psychiatrist, confidentiality could have been protected. If the psychiatrist's mishandling of the transference or countertransference accounts for his finding a job for Mr. A, then the rule of abstinence has been disregarded and a boundary violation has occurred. But within a sociocultural milieu of helpfulness and mutual support, the psychiatrist's employment intervention might be considered only a boundary crossing.

Even if not exploitive, the psychiatrist's job intervention may pressure Mr. A as well as the psychiatrist. For example, what obligation does Mr. A feel toward the psychiatrist? How will the feeling of obligation be manifested? If Mr. A's feeling of obligation toward the psychiatrist breeds resentment, will he be able to work through such feelings in therapy? The psychiatrist recalls a supervisor's comment during training that, "with some patients, no good deed goes unpunished." If the job does not work out, will Mr. A feel that he failed and disappointed the psychiatrist? Can Mr. A then complain or express anger at the psychiatrist for finding him the job? Can he now complain about the boss, the psychiatrist's friend, if difficulties arise in their work relationship? Will the psychiatrist feel that he has failed both Mr. A and his friend, if the work referral is unsuccessful?

Especially in small communities, confidential information that the patient authorizes for limited release may be carelessly leaked and disseminated.

Because the psychiatrist may interact with a patient in a variety of community settings and functions, extratherapeutic contacts can lead to involvements that compromise treatment boundaries and the psychiatrist's position of neutrality. Business dealings with patients or their families invariably create serious conflicts of interest for the mental health professional.

In addition, the maintenance of neutrality is seriously threatened when the psychiatrist appears as an expert witness for a patient (9,10). Particularly in small communities, mental health professionals may be asked to be experts in their patients' litigation. Other than being legally compelled to testify as a fact witness about diagnosis, treatment, and prognosis, the psychiatrist should inform the patient that a nontreating practitioner should serve as an expert witness to provide testimony about causation and damages (11). Attorneys routinely retain expert witnesses from all parts of the country. Nevertheless, the dual role of treatment provider and forensic expert cannot always be avoided in small towns and rural areas. The psychiatrist may go to court expecting to testify as a fact witness but may be converted by the judge into an expert witness.

Confidentiality

The maintenance of confidentiality can be particularly problematic in small communities and rural areas. Concerned family and community members may mount considerable pressure on the psychiatrist to disclose information about the patient. Fears about stigmatization may cause individuals to avoid necessary treatment or to be very worried about breaches of confidentiality if they do come for treatment.

Especially in small communities, confidential information that is authorized for release by the patient may be carelessly leaked and disseminated. For example, diagnostic and treatment information released locally for insurance purposes may be seen by individuals who know the patient. Small communities often present inherent and inescapable confidentiality problems. Neighbors and other community residents may observe the patient going to and from the psychiatrist's office.

It is incumbent on psychiatrists and other therapists to discuss anticipated confidentiality issues at the beginning of treatment. A sound policy is not to release patient information without

the patient's written authorization unless the release is required by a court order. Also, the patient should be allowed to review and approve any information before it is released. Obviously, if confidentiality and appropriate treatment boundaries cannot be maintained, the psychiatrist cannot treat the patient. The vignettes below illustrate some of the confidentiality dilemmas that arise in small communities and rural areas.

Personal relationships with patients

Ensuring that the psychiatrist has no previous, current, or future personal relationships with a patient can be extremely difficult or even impossible in small communities. The psychiatrist may have met or may personally know a number of the community's residents, especially if he or she was raised there. If the psychiatrist is married and also has children, his or her sphere of knowledge of and contact with other members of the community is greatly enlarged. In small communities, it is likely that the psychiatrist will also encounter and interact with former patients.

In considering the guideline about avoiding personal relationships with patients, much depends on the interpretation of what constitutes a personal relationship. Obviously relatives, childhood friends, close adult friends, and professional peers would easily qualify as personal relationships. A superficial acquaintance with a prospective patient may not necessarily be a contraindication to beginning treatment. The nature of the treatment may also be a determining factor. If the psychiatrist is primarily prescribing medication rather than conducting psychotherapy, an acquaintance with the patient may be less problematic.

An initial period of evaluation may help clarify the issue. When the psychiatrist is the only mental health provider in a rural community and no other mental health professionals are available for hundreds of miles, he or she would find it very difficult to turn away a friend or relative who is in need of treatment, particularly in an emergency. The psychiatrist can conduct an initial evaluation to determine the nature of the problem and the treatment required. To do otherwise would be to add insensitivity to injury. In this instance, doing the humane thing takes precedence over the rigid observance of boundary guidelines. In the likely event that the patient will require referral, the psychiatrist can explain in a clinically supportive way that the personal relationship between the psychiatrist and the patient will interfere with objective treatment. A useful analogy to convey to the patient might be "It would be like a doctor trying to treat himself."

Vignette

A psychiatrist practices in a small rural community. She is the only psychiatrist within 380 miles of the nearest mental health center and psychiatric hospital. A nephew on her husband's side, Mr. C, becomes acutely psychotic after a failed relationship. Mr. C's parents call the psychiatrist who immediately evaluates and treats him with antipsychotic medication. The psychiatrist recommends to the family that he be transferred to a psychiatric hospital. The family is unwilling because the inpatient facility is so far away, making visiting an arduous task.

Treating family members or personal friends does not usually turn out well for either the psychiatrist or the patient.

The psychiatrist is reluctant to provide more than emergency treatment. However, she continues to treat and manage Mr. C as an outpatient because of family pressures. His family presses her continually for information about his treatment. Mr. C is delusional and very mistrustful. He does not want any information provided to his family. The family feels desperate, appealing to the psychiatrist's husband, which causes stress in her marriage. She reluctantly provides some general information about the treatment after discussion with Mr. C, who angrily acquiesces to family pressure. He is seen for once-a-week supportive psychotherapy and medication follow-up for six months, at which point he experiences an exacerbation and attempts suicide by overdose.

The psychiatrist does not hesitate at this point to transfer Mr. C to the psychiatric hospital. She feels enormously relieved. She does not bill Mr. C or his family. The inpatient psychiatrist tells the family that Mr. C was not receiving a sufficient dose of antipsychotic medication and therefore relapsed. His family openly expresses feelings of anger and disappointment that their own relative did not properly treat their son. The psychiatrist is very disturbed by her in-law's criticism. She explains that Mr. C was maintained on a dosage of medication sufficient to manage his psychosis but not at a level that would impair his functioning. A rift develops in the family.

Discussion

Most psychiatrists avoid treating patients with whom they have had a past or current personal relationship. In small communities, however, considerable flexibility must be allowed concerning this boundary guideline. The psychiatrist will likely be on a first-name basis with many community members. The psychiatrist may come into contact with persons who are, have been, or may become patients. This situation is a reality of psychiatric practice in a small community. Thus the treatment of acquaintances that would likely be considered a boundary violation in larger cities may require only boundary adjustments in small or rural communities. Boundary adjustments are often justifiable in such circumstances, as long as the therapeutic objectives are supported without creating boundary violations.

As the vignette shows, treating family members or personal friends does not usually turn out well for either the psychiatrist or the patient. For the psychiatrist caught in this dilemma, the best course of action is to provide emergency treatment for the relative or personal friend and then refer the patient, if at all possible. Psychiatrists and other therapists practicing in rural settings without benefit of colleagues might consider recruiting mental health personnel or training qualified, suitable individuals in the community to provide mental health support services.

In the vignette, the psychiatrist succumbs to the demanding family members. She goes against her better clinical judgment in not hospitalizing her psychotic nephew. Insurmountable transference and countertransference problems that impair clinical judgment inevitably arise in the treatment of family members. Issues of billing family member for professional services are particularly disruptive. Billing family members usually causes animosities and dissension in the family. Not billing a patient creates the illusion of a personal rather than a professional relationship between the psychiatrist and patient, especially when psychiatrist and patient have had a previous relationship.

Confidentiality problems loom large when the psychiatrist attempts to treat relatives or personal friends. The patient's family members may feel entitled to receive information about the patient because of their special relationship with the psychiatrist. The psychiatrist may fail to maintain confidentiality because of his or her concerns about damaging or losing family relationships. Protecting confidentiality is a core boundary guideline in any setting, although exceptions do exist (12).

Anonymity and self-disclosure

Self-disclosure by psychiatrists and other therapists is a complex topic (13). Self-disclosures that demonstrate the practitioner's struggle with problems of living can be supportive to some patients. However, the patient may feel burdened by the therapist's self-disclosures of current conflicts or crises. Self-disclosures may also create role reversal in which the patient attempts to rescue the therapist. Sexual fantasies or dreams about the patient or others should not be shared with the patient under any circumstances. Self-disclosures by therapists have a high correlation with subsequent therapist-patient sex (14).

In small rural communities, the anonymity of mental health professionals is largely a fiction. To a degree, their personal lives may be common knowledge in towns "where everyone knows everybody's business." The patient may have had or may continue to have contact with the psychiatrist at various community events. If the psychiatrist is married and has children, the patient may have had past or current contact with his or her family. If the psychiatrist practices in a community where he or she grew up, the patient and the patient's family may know or may have known the clinician's original family.

During the segment of the treatment session that occurs between the chair and the door, patients and therapists are more vulnerable to committing boundary crossings or violations.

Vignette

A young unmarried psychotherapist, a nonmedical mental health professional, practices in the small mountain community where he grew up. He begins the treatment of a female patient who has had a recent onset of panic attacks. Ms. B is placed on medication by her family physician and is seen once a week for insight psychotherapy by the therapist.

The therapist knew Ms. B as an acquaintance in high school. The therapist remembers that he admired and felt attracted to her when they were both high school students. He was shy and kept his feelings to himself. No dating occurred.

The therapist and Ms. B address each other by their first names. The sessions begin with a brief period of chit-chat. Also, after the session is concluded, Ms. B and therapist usually talk briefly about various events in the community. Because they were acquainted with each other before, it is easy for them to converse about past experiences, old friends, and other matters of mutual interest. The conversations that occur between the chair and the door become more lengthy and intense over time. Ms. B is improving steadily. She and the therapist progress from a handshake to a "supportive hug" as she leaves the session. The therapist realizes that his earlier attraction for Ms. B is reawakened. He notes that the treatment sessions have gradually become more social and less treatment focused.

The therapist stops the hugs and attempts to sensitively re-establish appropriate boundaries by restricting the "socializing" before and after the session. Ms. B questions this change and reacts with feelings of rejection. The therapist explains in a clinically supportive manner that it is important not to let the therapy become a social hour. Ms. B states she felt more comfortable with the earlier informality of the sessions. Within a few weeks, she leaves therapy, stating that she feels better and sees no need for further treatment. However, the therapist hears later from others in the community that she was unhappy with him and the treatment.

Discussion

The friendliness and familiarity that may exist between members of a small community may carry over into treatment, necessitating flexible boundary adjustments. For example, therapist and patient may comfortably address each other by their first names. However, damaging boundary viola-

tions usually begin insidiously and can become progressive (15). During the segment of the treatment session that occurs between the chair and the door, patients and therapists are more vulnerable to committing boundary crossings or violations. Early boundary violations with a potential for damaging progression generally first appear within this interval. Both therapist and patient may be tempted to cast off their respective roles prematurely, launching into social exchanges before the patient leaves. In small communities, a friendly familiarity that may exist can permanently disrupt treatment boundaries by introducing deviations in the transition zone between the chair and the door. The beginning and the ending of sessions should be carefully scrutinized for boundary infractions (16).

In the vignette, the therapist becomes aware of boundary crossings at the beginning and at the end of the sessions with the patient. Hugging the patient at the end of the hour alerts the therapist that early boundary violations are occurring. The patient's complaint about the resetting of boundaries is a boundary issue that is grist for the therapeutic mill. Hugging the patient violates the rule of abstinence when it serves the personal needs of the therapist. Moreover, hugging a patient is rarely free of erotic elements (17,18).

The negative outcome in the vignette is primarily a result of the therapist's countertransference that drives the boundary violations. Unrecognized countertransference feelings are frequently the cause of damaging treatment boundary violations. Small communities and rural settings provide a wide variety of occasions for difficult transference and countertransference developments. A major source of countertransference is the worry, or even fear, that a patient may "bad mouth" the psychiatrist or therapist, perhaps damaging his or her professional reputation in the community.

Poor training, lack of experience, and characterological problems of the therapist may also contribute to poor boundary maintenance. In small communities and rural settings, the opportunity for supervision may be limited or nonexistent. A thorough familiarity with the professional literature on treatment boundaries may be helpful to the practitioner who practices in geographic isolation.

Fees

A stable fee policy requires that the psychiatrist be paid with money only (19). In small communities or in rural settings, employment may be seasonal or dependent on favorable weather and economic conditions. Patients who are undergoing treatment may find that they are unable to pay their bills. At the same time, they may require continuing treatment. In lieu of monetary payment, the patient may be willing to barter services, cars, jewelry, real property, and other valuable items. Nevertheless, the coin of realm should literally be money because patients who desperately need treatment or who experience strong transference feelings toward the psychiatrist may be unable to make an arms-length assessment of the monetary value of their services or possessions.

Treating an impecunious patient for no fee might feel like the right human response but would likely be destructive to any current or ongoing therapy.

Vignette

A psychiatrist practices in an island community whose economy is heavily dependent on farming. She is the only psychiatrist on the island. The psychiatrist's fee is $100 per session. She begins treatment of a patient who has a postpartum depression. Ms. D is placed on an antidepressant and provided bimonthly supportive psychotherapy. After eight weeks of treatment, Ms. D informs her psychiatrist that she can no longer afford to pay for treatment. Although she has made steady progress, she agrees with her psychiatrist that more treatment is necessary.

Ms. D's husband, a farmer, is engaged in vegetable farming. He also owns the only poultry farm on the island. He is acquainted with both the psychiatrist and her husband. He offers to barter his services for the doctor's fees. The psychiatrist and her husband live on three acres of land, two acres of which lie fallow. Ms. D's husband offers to cultivate the two acres of land and produce a crop of melons, which would earn the psychiatrist a profit of at least $2,000, the equivalent of 20 sessions.

The psychiatrist's husband has recently retired. He would like to start a poultry business. The psychiatrist suggests instead that she will accept 5,000 chicks as payment in full, provided the treatment does not go beyond a year. The patient's husband reluctantly agrees to provide the chicks from his poultry stock, fully realizing that he is establishing a competitor for his up-to-now monopoly poultry business.

Poultry is not a commodity whose daily price is stable. At the time of the barter agreement, the chicks are estimated to be worth approximately 30 to 36 cents each, or $1,500 to $1,800, the equivalent of 15 to 18 sessions. Seven months later, a lethal flu virus, very dangerous to humans and thought to be carried by chickens, is discovered overseas. Millions of chickens are sacrificed, dramatically driving up the price of poultry in flu-free areas of the world such as the island.

The psychiatrist's husband makes a windfall profit in his new poultry business. Ms. D's husband is angry that his poultry profits were considerably reduced by the barter and by the competition. He complains bitterly to other members of the community. Ms. D successfully completes treatment but her depression relapses within a year. She does not feel that

she can return to the psychiatrist, given her husband's anger that he was exploited by the barter.

Discussion

The psychiatrist in the clinical vignette had other options she could pursue once the patient was no longer able to pay for treatment. Psychiatrists may ethically elect not to continue to treat a nonemergency patient who is unable to pay for treatment. In small communities where the psychiatrist is the only mental health care provider, termination of therapy with a patient may not be a simple option. It is consistent with sound boundary maintenance to work out a flexible payment plan with the patient. Also, the patient may be able to obtain a loan or raise money in other ways. If the psychiatrist is faced with an impecunious patient requiring emergency or short-term treatment, a token fee may be arranged. Treating the patient for free might feel like the right human response but would likely be destructive to any current or ongoing therapy.

In the vignette, Ms. D's continued need for treatment and the psychiatrist's dominant position as a care provider made the barter transaction unequal. Moreover, Ms. D's husband expressed misgivings about the barter arrangement. The intrusion of the business dealings of the psychiatrist's husband into the payment arrangement was not only a breach of confidentiality but a clear conflict of interest and a violation of the rule of abstinence. Although the barter arrangement allowed the patient to continue treatment, the exchange of goods for services was an exploitation that furthered the personal business interests of the psychiatrist and her husband.

The vignette illustrates the danger of bartering arrangements between psychiatrists and their patients. One or both may later feel betrayed and exploited by such agreements. Bartering arrangements make it difficult to determine the actual monetary value of a transaction. The extrinsic value of money—that is, what it buys—can be readily determined. The intrinsic or emotional value that people place on money is extremely elusive, having no extrinsic marketplace measure. Patients who are mentally ill and desperate for help may have a distorted emotional perception of the value of their money, making extrinsic monetary evaluations very difficult.

Conclusions

Boundary crossing and violations are endemic to psychiatric practice, regardless of the venue. Psychiatrists and other therapists practicing in small and rural communities face special problems in maintaining neutrality; fostering patient separateness; protecting confidentiality; managing past, current, or future personal relationships with patients; and maintaining a flexible but professional fee policy. Boundary guidelines must be applied flexibly, especially in the context of small communities. Reference to the rule of abstinence should help the psychiatrist differentiate between boundary crossing and boundary violations. The ability to sensitively manage boundary issues as well as identify and therapeutically correct boundary crossings and violations will help maintain the safety and integrity of the therapeutic process, no matter what the treatment setting (20). ♦

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