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Ethics Commentary

Ethical Challenges in the Treatment of Anxiety

Mental health professionals routinely encounter situations that pose ethical challenges to the provider and stress the clinician-patient relationship. These situations are often rendered more difficult because of physiological, financial, and other contextual factors that contributed to or resulted from the mental illness. Approaching these challenges in a manner that is informed by the six cardinal principles of medical ethics—beneficence, nonmaleficence, autonomy, respect for persons, confidentiality, and veracity—can help the clinician navigate the dilemmas at hand and offer superior care and sound advice despite the uncertainty brought by these situations (1, 2). As the following examples taken from patients with obsessive-compulsive disorder, generalized anxiety disorder, and panic disorder can help illustrate, care for the anxious patient, like care for any patient, is better when delivered within an ethical framework that is defined by those principles (2).

Nonmaleficence and respect for persons

TA is a 59-year-old single unemployed white woman with obsessive-compulsive disorder (OCD), manifesting primarily in hoarding symptoms. She lives on a limited income in rent-controlled housing. She first presented for treatment after receiving an eviction notice from her landlady because her paper collections posed a fire hazard to the building. Lacking medical insurance, she sought subsidized treatment through a trainee clinic where psychiatric residents, supervised by an attending psychiatrist, rotated every 6 months.

TA's symptoms responded very well to a combination of medications and weekly psychotherapy obtained through the clinic. However, she would become restless and agitated with each anticipated resident switch. Although provider transitions can be stressful, it gradually became clear to the supervising psychiatrist that TA's biannual exacerbation was primarily motivated by concern that her next clinician might be of a race different from hers. As an example, she was once concerned that she might be assigned to an Asian trainee and urged the clinic director to "spare me Dr. Bok Choy," a reference to the Chinese vegetable. She would also try to discuss residents with ancillary staff in an attempt to infer their race. In another possible manifestation of xenophobic thinking, she rejected generic drugs imported from countries as varied as Israel, India, and Brazil, insisting, instead, that any medication being considered for her be available from a U.S.-based manufacturer.

The negative counter transference TA engendered in individuals involved in her care was substantial, and several staff members felt she should be banned from the clinic. The attending psychiatrist, however, decided against termination. Her decision rested on two overriding principles of medical ethics: *nonmaleficence*, defined as the duty to avoid doing harm (3), and *respect for persons,* which, in clinical care, represents the virtue of according intrinsic value to the patient (3). A decision to terminate treatment would have constituted patient abandonment, worsened by the fact that this medically uninsured, indigent, and "difficult" patient was vulnerable and would very likely not find another provider willing to accept her into his or her practice. Without continued help from medications and weekly psychotherapy, she would probably experience a relapse into OCD symptoms. Her collections would probably grow and become a fire hazard again, potentially triggering eviction proceedings that might leave her homeless. The psychiatrist's duty to nonmaleficence dictated that a

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CME Disclosure

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challenging situation be tolerated and worked through to prevent greater harm to the patient.

Respect for persons is the other guiding principle at play. It requires that the clinician serve the well-being of the patient without judgment and with regard for the patient's dignity, regardless of provocation or countertransference, and even if, as in this case, the patient might be exhibiting the opposite behavior herself. Disrespectful behavior on the patient's part does not suspend or relax this duty—the patient still enjoys innate value and worth and still deserves genuine consideration. The understandable feelings she engenders in caregivers and staff are better handled through processing attempts and mutual support, as well as clear limit-setting with the patient, rather than by patient abandonment (3).

BENEFICENCE AND PATIENT AUTONOMY

PT is an otherwise healthy 48-year-old unemployed teacher with severe generalized anxiety disorder, diagnosed in her early 20s. She presents as globally anxious with multiple sources of worry, including her physical health, her husband's well-being, family finances, and the state of the environment. She is unable to drive for fear she might get into an accident and has never had a Pap smear or a mammogram for fear she might be diagnosed with cancer. Her symptoms prevent her from working. Despite having received, sequentially and over several years, multiple forms of psychotherapy, including cognitive behavior therapy, her symptoms have remained debilitating. She continues to report to clinic for weekly supportive psychotherapy but consistently refuses her psychiatrist's recommendation for a medication trial. Drugs as varied as the serotonin reuptake inhibitors, benzodiazepines, buspirone, gabapentin, and hydroxyzine were all rejected because of her anxious fear of side effects. Although she acknowledges being severely impaired by her symptoms, PT's fear of a possible adverse reaction that might make her feel even worse has prevented her from agreeing to a recommended drug trial that might prove beneficial to her anxiety.

This case illustrates the concepts of *beneficence* and *patient autonomy* as they interact and, in this case, collide in the crucial process of obtaining a patient's informed consent for treatment. In medical ethics, beneficence signifies the obligation to benefit patients and seek their good (3), whereas autonomy represents the ability to make reasoned decisions for oneself and act on the basis of such decisions (3). In this case, the physician's duty to act beneficently, i.e., to seek the patient's good by strongly recommending psychopharmacological treatment to someone who is unlikely to improve from continued psychotherapy alone, is in tension with his obligation to respect the patient's autonomy. The psychiatrist determined that his patient had decisional capacity to refuse a treatment which he believed offered her the best chance for improvement. He came to this determination because the patient met the four standards seen to constitute decisional capacity (4–6):

1) the ability to communicate unambiguously her preference;
2) an understanding of the information needed to reach the specific decision (in this case an understanding of the potential for positive and negative outcomes when trying a medication);
3) an appreciation of the severity of her symptoms and of how impaired she is as a direct consequence of having them; and
4) the ability to reason, by which is meant the capacity to weigh information, consider alternative treatments, and understand the consequence of no pharmacological treatment at all. Having determined, on the basis of these criteria, that his patient had the decisional capacity to refuse his recommended treatment, he appropriately decided to continue to provide psychotherapy alone.

VERACITY AND CONFIDENTIALITY

ST is a 38-year-old married computer engineer with a diagnosis of chronic, previously untreated, panic disorder with agoraphobia. His symptoms included great fear of air travel and significant difficulty crossing bridges. While his wife of 6 years was undergoing infertility treatment and suffering from mood swings as a result of exogenous hormones, ST started an affair with a woman he met in a chat room. However, spending time with her necessitated having to drive across the bridge that separates the city where he lives from his lover's city of residence. Showing new motivation to seek treatment, ST decided to start seeing a psychiatrist for the first time. He requested, however, that the diagnostic code used for insurance billing purposes be "adjustment reaction with anxious mood" (deriving from stress around infertility problems), rather than the more accurate "panic disorder with agoraphobia." In ST's assessment, the former carried less risk of insurance denial in the future, because it can be viewed as a short-lived reaction to a temporary stressor rather than a chronic condition.

ST's psychiatrist refused. In doing so, she was

upholding the ethical principle of *veracity*, defined as the duty to be truthful and avoid misrepresentations and misimpressions (3). Although in tension with the principle of nonmaleficence (avoiding the harm that might result from potentially precluding ST from being able to purchase future mental health insurance), she determined that truthfully documenting the presenting problem and honestly describing and justifying the interventions being undertaken were of a higher ethical order. To help allay his anxiety around the possibility of future problems with obtaining insurance, she discussed with him ways to access subsidized treatment should he need it.

ST accepted his psychiatrist's decision and remained engaged in the gradual exposure therapy approach and in using relaxation tools to help calm the anxiety that accompanied the exposure. By the eighth session, ST was a much more capable driver. His improved anxiety was obvious to his wife, too—ST was now able to be the driver more often when the couple would travel together. But despite the reduction in his anxiety, ST seemed more distant and disengaged from her. She had expected that the opposite would happen, especially since she was experiencing the stress of hormone treatment and was in need of his support. In an attempt to understand the paradox, she insisted on meeting his therapist. Although ST asked that his wife not be informed about the affair, he consented to the meeting.

During the conversation, the psychiatrist may have felt a need to indirectly warn the wife of her husband's infidelity and of the problematic relationship within which she was trying to conceive. Her primary ethical duty, however, was to her patient and to the principle of *confidentiality* that is built into that relationship. Defined as the obligation not to disclose information obtained from patients or observed about them without their permission (3), confidentiality has been an acknowledged duty of physicians at least since Hippocrates wrote: "What I may see or hear in the course of treatment…in regard to the life of men…I will keep to myself, holding such things to be shameful to be spoken about" (7). Only extraordinary circumstances such as suspected child or elder abuse or an imminent threat to a third party would allow a practitioner to suspend the duty to protect confidentiality (3). This case did not meet those criteria, and the psychiatrist correctly decided to strongly recommend marriage counseling and to explore relationship issues in more depth with her patient.

PROVIDER ANXIETY

Bioethical principles have a universality that transcends diagnoses and that makes them applicable and binding whether the patient is seeking help for complications from cardiovascular disease or anxiety related to posttraumatic stress disorder. In that regard, anxiety disorders are no different than other psychiatric or medical conditions. But regardless of the illness bringing the patient to the clinician's attention, one reaction familiar to clinicians facing an ethical dilemma in their practice is anxiety—for the patient's well-being, about "doing the right thing," over medico-legal repercussions, and so on. As the cases above suggest, the cardinal principles of medical ethics are relevant and helpful dictates, not abstract notions. Approaching the ethically challenging, anxiety-producing situation in a manner that is consciously mindful of them and systematically applying them as cases warrant helps allay provider anxiety and, more importantly, helps ensure high-quality, ethically sound, patient care.

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