Ethical Challenges in the Treatment of Anxiety

Jarrod A. Marks, M.D., Samuel Rosenblatt, B.A., James L. Knoll IV, M.D.

Anxiety is sometimes referred to as the "fever" of psychiatry (1). The state of anxiety is very common and is perhaps one of the most nonspecific symptoms in psychiatry. A great deal of psychiatric and philosophical theory has emerged around anxiety as a feeling state that is normal and perhaps even adaptive. Søren Kierkegaard famously described anxiety as being the "dizziness of freedom" (2) that living beings with the ability to choose inevitably feel. On the other hand, pathological disorders—collectively termed in the *DSM-5* as anxiety disorders—are some of the most commonly diagnosed in psychiatry. It is estimated that one in four people meet the diagnostic criteria for at least one anxiety disorder, with a 12-month prevalence rate of 17.7% (3).

Unique challenges in the evaluation and treatment of anxiety give rise to various ethical problems. This column illustrates several ethical concepts, including various aspects of informed consent, the boundaries of treatment, confidentiality, and the conceptualization of treatment itself through several case vignettes. First, we address the anxiety formulation that will resurface in the vignettes.

The Anxiety Formulation

Anxiety is a universal human phenomenon. It represents a feeling state that often includes unpleasant apprehension along with various autonomic symptoms, including palpitations or increased heart rate. The *DSM-5* distinguishes between fear and anxiety, which can also overlap. Whereas fear is a response to a real or perceived imminent threat, anxiety is the anticipation of some future threat.

The most important distinction that a psychiatrist must make when evaluating a patient experiencing anxiety is whether the anxiety is part of a disease process or part of the normative range of human experience. Anxiety disorders differ from developmentally normative fear or anxiety in that the former are "excessive or persisting beyond developmentally appropriate periods" (4). Further, distinguishing normative from excessive anxiety may require exploration of cultural factors. The search for the existence of a disease process is particularly important in the Hippocratic tradition of medicine, which seeks to treat diseases and manage symptoms conservatively.

As the following vignettes illustrate, the distinction between management of symptoms and treatment of disease process has an important effect on the ultimate prognosis and course of illness. For example, if a patient's anxiety is caused primarily by a psychotic illness, management of anxiety as an isolated symptom will lead to a different clinical outcome than would treatment focused on the psychotic illness itself. From an ethical perspective, distinguishing between isolated symptoms and disease process will affect the informed consent process, specifically relating to a complete discussion of the patient's condition and its probable course. The explanatory model discussed with the patient will affect the patient's treatment decisions. For example, a patient might be inclined to accept pharmacological treatment for anxiety related to a chronic illness that is likely to persist or worsen without disease-modifying treatment. However, the same patient may choose to engage in psychotherapy or no treatment at all for anxiety related to the stresses of life, with no apparent underlying disease process.

Distinguishing pathological from normative-range anxiety can be challenging. Within the realm of pathological anxiety, the discerning clinician must explore whether the anxiety is due to a general medical condition (e.g., hyperthyroidism), whether it is a primary anxiety disorder (such as a phobia), or whether it is a symptom of an underlying mood or psychotic illness. To make matters more complicated, all three types of anxiety can co-occur in various permutations. For example, anxiety due to posttraumatic stress disorder may be exacerbated by thyroid disease. Thus, careful attention must be given to teasing out the causes and temporal relationships of anxiety symptoms. The clinician must keep in mind that anxiety disorders are often highly comorbid conditions. Differentiation and diagnosis often depend upon taking a careful general medical and psychiatric history in addition to delineating "the types of situations that are feared or avoided and the content of the associated thoughts or beliefs" (4).

Table 1 gives a nonexhaustive list of the most common types of anxiety seen in psychiatric practice. As we discuss later, identifying anxiety as part of a psychotic or affective illness is important clinically and ethically as part of the informed consent process.

We write this column in the midst of a global pandemic. Symptoms of anxiety and depression have increased considerably since the COVID-19 pandemic began (5). Many people are experiencing unprecedented levels of loss, grief, and constraints in life—and bearing it all while feeling more alone and isolated than ever before.

We would expect to see a rise in existential anxiety during these times, with an increased awareness (or new awareness) of mortality. For some patients, things that used to cause anxiety, such as college coursework and tests, are now more anxiety provoking in new virtual formats. At the same time, illnesses such as schizophrenia and bipolar disorder are newly emerging in patients. Patients who have lived with these disorders since before the pandemic may see worsening symptoms from added stress and isolation. During this era of COVID-19, clinicians must continue to use their diagnostic acumen to consider all possible causes of anxiety.

TABLE 1. Common types of anxiety seen in psychiatric practice[a]

Anxiety type	Examples
Anxiety illness due to another medical condition	Thyroid disease, pheochromocytoma
Personality trait	Anxious, avoidant, dependent
Mood illness related	Unipolar depression, bipolar illness
Psychotic illness related	Schizophrenia, depression with psychotic features
Primary anxiety illness	Posttraumatic stress disorder, specific phobia
Existential anxiety	Fear of death and impermanence

[a] Adapted from Ghaemi (1, pp. 273–280).

Case 1, Part 1

Mr. C is a 23-year-old man who presents to a resident psychiatry clinic during the COVID-19 pandemic with a chief complaint of overwhelming anxiety. The psychiatry resident, Dr. Smith, interviewed the patient. Mr. C reported that since the pandemic started, he has had increased anxiety, which makes it difficult for him to concentrate at work. He stated that he thinks a lot about COVID-19 and the possibility that he or one of his family members will become infected. He reported that when he is anxious, he has an increased heart rate and upset stomach and often feels restless. Dr. Smith noticed that the patient was speaking very fast. When asked more about the thoughts he has regarding the pandemic, he started crying and said, "I am so afraid of what might happen. I am afraid of my family dying and of my own death." He then stated, "I don't really want to talk about this anymore. I'd like to end now. Can you give me a medicine for my anxiety?"

1.1 What would be the most appropriate response to Mr. C's question?

A. "I'm sorry you want to end now, but we must continue with the interview."
B. "This sounds like normal anxiety to me. I don't think you need any medication."
C. "I understand that you are suffering. I can write you a prescription for your anxiety now, and we can continue this conversation next session."
D. "I understand that this is difficult for you to talk about. In order for me to best help you, I will need some more information, but we can go at your pace."

Case 1, Part 2

Mr. C decides to take a 5-minute break and returns to continue the interview. Dr. Smith asks him some more questions. When asked about sleep, Mr. C reported that he has been sleeping only 3–4 hours per night because he "isn't tired." He also told Dr. Smith that, according to his parents, he has been "talking fast," and they think that he is having a manic episode. When asked about family history, Mr. C reported that both his mother and brother were diagnosed as having bipolar disorder and are doing well on lithium.

Dr. Smith concludes that Mr. C most likely has an underlying bipolar disorder that is causing or contributing to his anxiety. Dr. Smith immediately recalls learning that anxiety disorder comorbidity is prevalent and seems to be an independent marker of more severe bipolar illness and suicide attempts (6). After doing a thorough suicide risk assessment, he uncovers that Mr. C has been having suicidal ideas for the past 3 weeks, and Dr. Smith believes that the patient's risk for suicide is high. Dr. Smith encourages Mr. C to consider an inpatient admission for a more thorough psychiatric evaluation, lab tests, and physical exam. Mr. C agrees with this plan and is voluntarily admitted to the inpatient psychiatry unit.

While on the inpatient unit, Mr. C's inpatient psychiatrist agreed with the diagnosis of bipolar disorder and proposed starting Mr. C on a mood stabilizer. To do so, informed consent was obtained from Mr. C.

1.2 Which of the following are the three components of informed consent?

A. Information disclosure
B. Clarity
C. Voluntariness
D. Confidentiality E. Decision-making capacity

1.3 Which of the following is not a generally accepted exception to informed consent?

A. Emergencies
B. Lack of patient decision-making capacity
C. Patient waiver
D. Lack of time for information disclosure
E. Therapeutic privilege
F. Court-ordered involuntary treatment

1.4 Which theory of ethics involves balancing conflicting duties and values to resolve conflicts in order to determine the most ethical action?

A. Deontology
B. Utilitarianism
C. Dialectical principlism
D. Social contract theory
E. Moral relativism

Case 2, Part 1

Mrs. D is a 62-year-old woman who presents to a psychiatrist with a chief complaint of cynophobia, the fear of dogs. Mrs. D explains that she has been afraid of dogs her whole life. She thinks that the fear started when she was a child, when a neighbor's dog bit her hand while she was trying to feed the dog. Whenever she sees a dog, hears a dog barking, or even imagines a dog, she becomes extremely frightened and anxious. The anxiety is so overwhelming that it sometimes leads to panic symptoms. She has avoided living in any building that permits animals and is unable to visit her friends who have dogs as pets.

She never presented for psychiatric help until now, because she has been able to endure the anxiety surrounding the phobia and has managed to avoid situations where she may encounter a dog. Last month, her daughter gave birth to twins, and her daughter is desperate for Mrs. D to come to the house to help with the babies. However, the daughter has two small dogs that have, until now, prevented Mrs. D from visiting her own daughter for many years.

The psychiatrist explains the diagnosis of specific phobia to Mrs. D, including the nature and prognosis of the condition.

2.1 Suppose the psychiatrist recommends a trial of a selective serotonin reuptake inhibitor to address the patient's anxiety symptoms but does not offer alternative viable treatments for specific phobia. What ethical principle(s) may come into question?

A. Confidentiality
B. Justice
C. Informed consent
D. Autonomy

Case 2, Part 2

The psychiatrist presents the patient with several treatment options, including psychotherapy. Mrs. C decides that she would like to pursue systematic desensitization, which will involve graded exposure to the relevant anxiety-provoking stimuli. At first, the therapy will involve imagining dogs. It will then proceed to watching film clips containing dogs. Finally, the psychiatrist and patient will attempt to desensitize in vivo at a local dog shelter.

2.2 What are some ethical or clinical challenges that might arise for the psychiatrist when conducting this form of treatment?

A. Increasing Mrs. D's anxiety during the treatment
B. Departure from the typical setting of psychotherapy
C. Issues involving confidentiality outside of the office
D. All of the above

2.3 Which of the following would likely be considered a boundary crossing by the psychiatrist, as opposed to a boundary violation?

A. Visiting a dog shelter with Mrs. D during the therapy session
B. Having dinner with Mrs. D outside of the therapy session
C. Giving Mrs. D several long, comforting hugs whenever she has a panic attack at the dog shelter
D. Disclosing personal problems to Mrs. D during the therapy session

Answers

1.1 The answer is D. By this point in the interview, Dr. Smith was able to gather some limited information about the patient's experience of anxiety and his worries surrounding the COVID-19 pandemic. However, it is unclear whether the anxiety is normal or existential anxiety or whether it is part of a mood or psychotic disorder. Demanding to continue with the interview (answer A) risks harming the therapeutic alliance. Concluding that the patient's anxiety is existential or normal (answer B) is premature, given the lack of a comprehensive initial interview. Giving a prescription at this point without gathering more information (answer C) risks foreclosing further exploration. Prescribing now also risks treating symptoms at the cost of missing an underlying disease process. The best choice is to encourage the patient to continue engaging while preserving the alliance being formed.

1.2 The answer is A, C, and E. Information disclosure, voluntariness, and decision-making capacity are the three core components of informed consent (7, 8). For the information component, the patient must be informed about the nature of condition, the risks and benefits of the proposed treatment, any viable alternative treatments, and the risks and benefits of no treatment. Patients should be offered the opportunity to ask questions. For voluntariness, the consent should be freely given without any coercion. For decision-making capacity, the patient must have the capacity to give consent.

1.3 The answer is D. Not having enough time to have a discussion regarding the proposed treatment does not create an exception to informed consent. Spending

inadequate time discussing informed consent issues with a patient may result in a poor therapeutic alliance, which increases the chances of a patient's treatment refusal (9). Generally accepted exceptions to informed consent (8) include emergencies, lack of capacity, patient waivers, and court-ordered involuntary treatment. In an emergency, informed consent may be waived to prioritize saving the patient's life (e.g., immediately medicating a patient who is harming himself in response to psychotic symptoms). Patients who lack the decision-making capacity to make treatment decisions are unable to give informed consent. Consent must generally be obtained from a substitute decision-maker. Informed consent is a right that can be waived by a patient. A patient may choose to waive the right to information disclosure or to consent. Some patients may choose to have another person give consent for them. Court-ordered involuntary treatment is generally predicated on the patient lacking the capacity to make his or her own treatment decisions. In this case, the judge is assuming the role of the treatment decision maker.

1.4 The answer is C. Dialectical principlism is "the method of prioritizing and balancing all types of conflicting principles, duties, and personal and societal values in a dialectic to resolve conflicts among them" (10). Utilitarianism is a family of ethical theories that deal with maximizing benefit for the greatest number of people. Deontology is a category of ethical theories primarily concerned with whether an action is right or wrong under certain rules, instead of being based on the consequences of the action. Social contract theory is the idea that moral obligations are based on an agreement or contract among members of a society including between the people and its government. Moral relativism is an idea that moral values are determined relative to a particular viewpoint, such as a certain society or historical period.

2.1 The answer is C and D. In general, patients have the right of self-governance, the ethical principle of autonomy. In the words of the renowned U.S. Supreme Court Justice Benjamin Cardozo, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body" (11). The patient must be given sufficient information to make decisions. Informed consent is the process by which this occurs. One of the core features of information disclosure is providing the patient with viable alternative treatment options along with their risks and benefits. A milestone malpractice case that brought this concept to light was *Oscheroff v. Chestnut Lodge* (12). In this case, a physician-patient Dr. Oscheroff was treated at Chestnut Lodge for approximately 7 months with psychoanalytic therapy. The patient continued to deteriorate, developing symptoms of a severe agitated depression. The patient was transferred to another hospital, where he was treated with medication. He improved and was discharged after several months. After he recovered, Dr. Oscheroff sued Chestnut Lodge, alleging that, among other things, the hospital failed to obtain informed consent by not disclosing and discussing alternative treatments.

2.2 The answer is D. Choice A is incorrect because Mrs. D is coming to the psychiatrist because her phobia and resulting anxiety are troublesome, and exposing Mrs. D to anxiety-provoking stimuli will almost certainly worsen her anxiety symptoms transiently. Some may consider this a form of harm, raising the principle of nonmaleficence. Other clinicians would argue that transient deterioration of symptoms may be a part of the therapeutic process, ultimately leading to a reduction of symptoms. Respect for the patient's autonomy would suggest that warning the patient of the risk of increased symptoms would be part of the informed consent process. Choice B: The frame and boundaries of the psychotherapeutic relationship exist to protect both the patient and the clinician. It allows the work to be done safely, creating the edges of appropriate behavior. Watching a movie with a patient or traveling outside of the office for sessions will most likely represent a deviation of frame for the psychiatrist's regular psychotherapy sessions. Such a deviation should be performed thoughtfully, and the psychiatrist should strive to preserve as much of the frame as possible (e.g., fees, meeting times) (13). Choice C: If the psychiatrist is to conduct a session outside of the office, there is a possibility that the patient or psychiatrist may encounter people they know. This possibility should be discussed ahead of time in session.

2.3 The answer is A. Boundary crossings represent deviations from the standard frame of treatment that are performed with a therapeutic purpose and are meant to be helpful to the patient. Boundary violations are deviations from the standard therapeutic frame that are harmful to the patient and may be meant to benefit the clinician (13). Visiting a dog shelter with the patient while attempting to preserve the other elements of the treatment frame is meant to help treat the patient and alleviate suffering. Social dining, intimate physical contact, and disclosing personal problems all lack therapeutic value and risk exploitation of the patient for the therapist's benefit.

AUTHOR AND ARTICLE INFORMATION

Department of Psychiatry, SUNY Upstate Medical University, Syracuse (Marks, Rosenblatt, Knoll). Send correspondence to Dr. Marks (jarrodamarks@gmail.com).

The authors report no financial relationships with commercial interests.

Focus 2021; 00:1–5; doi: 10.1176/appi.focus.20210001

REFERENCES

1. Ghaemi SN: Clinical Psychopharmacology: Principles and Practice. New York, Oxford University Press, 2019
2. Kierkegaard S: The Concept of Anxiety. New York, Liverlight, 2014
3. Sadock B, Sadock V, Ruiz P: Kaplan & Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry, 11th ed. Philadelphia, Wolters Kluwer, 2015
4. Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Arlington, VA, American Psychiatric Publishing, 2013
5. Indicators of Anxiety or Depression Based on Reported Frequency of Symptoms During Last 7 Days [Household Pulse Survey data table]. Atlanta, Centers for Disease Control and Prevention, National Center for Health Statistics, 2020. https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm
6. Simon NM, Otto MW, Wisniewski SR, et al: Anxiety disorder comorbidity in bipolar disorder patients: data from the first 500 participants in the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). Am J Psychiatry 2004; 161: 2222–2229
7. Gutheil TG, Appelbaum PS: Clinical Handbook of Psychiatry and the Law. Philadelphia, Wolters Kluwer, 2020
8. Appelbaum PS: Clinical practice. Assessment of patients' competence to consent to treatment. N Engl J Med 2007; 357:1834–1840
9. Buckley PF, Noffsinger SG, Smith DA, et al: Treatment of the psycho tic patient who is violent. Psychiatr Clin North Am 2003; 26: 231–272
10. Weinstock R: Dialectical principlism: an approach to finding the most ethical action. J Am Acad Psychiatry Law 2015; 43:10–20
11. Schloendorff v. Society of New York Hospital. 105 N.E. 92 (N.Y. 1914)
12. Stone AA: Law, science, and psychiatric malpractice: a response to Klerman's indictment of psychoanalytic psychiatry. Am J Psychiatry 1990; 147:419–427
13. Gutheil TG, Gabbard GO: The concept of boundaries in clinical practice: theoretical and risk-management dimensions. Am J Psychiatry 1993; 150:188–196