

# “No, I can’t be your...”: Boundary issues for health care professionals

The challenging therapeutic relationship between a caregiver and a youth with an eating disorder can lead to emotional exhaustion unless the caregiver seeks support and sets boundaries.

**ABSTRACT: Treating patients with eating disorders can arouse strong feelings in health care professionals. Treatment relationships can be intense and may be characterized by a lengthy period and a number of crises. To be effective, caregivers must be able to maintain an appropriate therapeutic alliance with the patient and be able to recognize and deal effectively with the affects such treatment can arouse.**

It is widely recognized that a good therapeutic relationship is needed for a health care professional to work effectively with a patient struggling with an eating disorder.<sup>1</sup> The nature of an eating disorder is such that it lends a certain intensity to the relationship with the patient, and relationship ruptures can easily occur.<sup>2</sup> Difficulties around themes of trust, hope, benevolence, and abandonment can be common. Being prepared for these difficulties can help you establish an effective alliance with the patient and deal with the strong feelings that can arise.

## The nature of eating disorders

Anorexia nervosa and bulimia nervosa are very serious disorders occurring primarily, but not exclusively, in adolescent and young adult females.<sup>3</sup> They are strongly “gendered disorders” and as a result may create a different set of concerns for male and female caregivers.<sup>4</sup> Treatment tends to be lengthy and may be characterized by a number of crises over time, including repeated hospitalizations, suicidality, self-mutilation, and a fluctuating and episodic course of symptomatology. Personality traits and

variables may lead to a very engaging relationship with the patient, and arouse a range of powerful feelings in the caregiver, including frustration, anger, compassion, hopelessness, and maternalistic or paternalistic feelings. The most common affects we see in trainees are feelings of powerlessness and inadequacy. Self-assessment in this area is critical if the caregiver is to avoid “blind spots.” This is not an area of work where treatment staff can see short-term results and quickly bolster their sense of professional efficacy and subsequent self-esteem.

Patients are also able to throw “emotional darts” at health care professionals and, through their behaviors, hook the caregiver and allied staff. For example, the patient’s behavior may engage the caregiver in providing a special or unusual degree of emotional nurturance or engender a

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prolonged attachment to the caregiver. It is as if the caregiver becomes involved personally in a push-pull scenario and struggle around the eating disorder. It is this type of engagement and the resulting feelings that may lead caregivers to feel overwhelmed and, as a result, question whether they can continue to provide care to such patients.

#### **How the patient may feel about the caregiver**

The patient will tend to see the caregiver (and want to see the caregiver) in terms of prior or current relationships with other significant figures in her life, a phenomenon termed "transference."<sup>5</sup> For example, the patient may see the caregiver as a savior, and then shortly afterwards feel abandoned by the same caregiver, or question how much the caregiver really cares. The dynamics of the relationship may appear to fluctuate dramatically. The patient may also see the caregiver as an abuser if hospitalization is necessary or if other restrictions need to be imposed.<sup>6</sup>

#### **How the caregiver may feel about the patient**

The caregiver may experience "countertransference," a phenomenon that has a long history in psychiatry and has had many meanings attributed to it.<sup>7</sup> For simplicity's sake, we may characterize countertransference as any feelings or thoughts that the caregiver has about the patient. These may or may not be based on unresolved issues from other relationships in the caregiver's life. It is a given that health care professionals will have feelings about the patients that they treat, and these feelings may arouse anxiety.<sup>8</sup> There may, for example, be a sense that the treatment or therapeutic interventions are inadequate compared with the patient's expressed or unex-

pressed needs. If the caregiver's sense of professional self-esteem is related to the degree to which the patient is benefiting from treatment, then she or he may well experience repeated emotional ups and downs.

Treatment providers may come to feel that they cannot meet the demands of the patient and as a result may feel depleted and emotionally exhausted, and may even be at risk of professional burnout.<sup>9</sup> The caregiver may feel that she or he does not have adequate resources for management of the eating disordered patient and therefore may be reluctant or even refuse to treat such a patient. Strong feelings of anxiety may tempt her or him to withdraw emotionally from the patient or to refer the patient to another health care professional entirely. The patient may feel rejected and abandoned under such circumstances, continuing a cycle of interpersonal failure.

Those patients who are at a Pre-contemplation or Contemplation stage<sup>10</sup> of change, as described elsewhere in this issue (see "A new treatment approach to eating disorders in youth") may arouse particularly strong affects on the part of the caregiver due to their marked ambivalence regarding treatment or their outright refusal of treatment.<sup>11</sup> Importantly, caregivers must recognize that this is demanding psychological work and that to be successful at it, they will need to be open to and aware of their feelings.

#### **Recommendations**

There are a number of steps the caregiver can take to establish an effective alliance with the patient and deal with boundary issues. First, health care professionals working in this area must acknowledge any feelings about patients and constantly seek to increase their awareness about them. There is nothing more dangerous than blind spots in this regard. Having feel-

ings about the patient with an eating disorder (or any patient for that matter) is normal. It is important to make a clear distinction between experiencing a range of feelings and yet not acting on them. Feelings may well be used as an important guide to various dynamics that may be evolving in the treatment relationship.

Second, do not make special accommodations for patients. An example would be to depart from your normal routine in order to accommodate a particular patient's requests, such as an unusual appointment time. Your feelings should be seen as red flags that can alert you to possible boundary crossings or to even more serious boundary violations.<sup>12</sup> For example, you should be aware that an overly strong sense of responsibility for the patient might be leading you to micro-manage aspects of the patient's life that the patient needs to take responsibility for. Where possible, encourage the patient to have a voice and make whatever decisions she is capable of while working to increase the patient's sense of interdependence with others.

Third, do not react hastily. Eating disorders have a way of making us all feel that at times we are in a crisis with patients and that unless we over-control the patient and usurp the patient's autonomy, chronic illness or death may result. These types of feelings are a recipe for professional stress and ultimately burnout. While safety issues must be attended to immediately, we have found through experience that working with eating disordered patients is long-term work and that it does not help patients or their treatment to be overly reactive or panicked in response to the most recent crisis. This means that the caregiver needs to develop a tolerance for her or his own anxiety. There are, for example, many issues that cannot be addressed in the short-term.

A fourth strategy that we have found helpful in the Eating Disorders Program is to view some aspects of the patient's behavior as a "test" around key developmental issues.<sup>13</sup> If the caregiver is able to recognize the behavior as such, respond with the appropriate degree of controlled neutrality, and not replicate unhealthy family dynamics, the potential for satisfactorily advancing the treatment is enhanced. An example would be the patient who has engaged in deliberate self-harm. Rather than being reactive, the caregiver needs to take a measured response that does not err on the side of over- or under-control of the patient.<sup>13</sup> Clinicians may find it helpful to consult literature on managing the relationship with patients with challenging personality traits.<sup>14,15</sup>

Fifth and last, we recommend that health care professionals seek consultation regularly when working in this area.<sup>16</sup> Our experience has been that feelings of shame regarding their feelings can impede caregivers from discussing issues with their colleagues and yet it is exactly these issues that can create relationship rupture.<sup>2</sup> Having the additional perspective of a trusted colleague, supervisor, or resource team can help the caregiver be aware of how the relationship with the patient has gone awry and how it may be repaired or strengthened so that the patient receives needed help and support.

## Conclusions

It is important to remember that patients can and do recover from an eating disorder.<sup>17</sup> Despite the difficulties associated with treatment, this is a very rewarding area to work in. As well as helping a group of patients who are struggling with a most pernicious illness, this work can teach us much about ourselves, our anxieties, and our own affects when faced with

an emaciated human being or one who feels out of control with binge eating and purging.

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### Competing interests

None declared.

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