PSYCHCEs

Exploring Dual Relationships and Boundary Crossings in Ethical Clinical Practice

Introduction

Dual relationships in behavioral health practice refer to any situations where multiple roles exist between a therapist and a client. Examples of dual relationships include when the client is also a student, friend, family member, employee, or business associate of the therapist. Boundary crossings and violations may occur in situations where dual relationships exist. While boundary crossings may be unavoidable and harmless in certain situations, such as when the clinician and client both live in a small community and see each other away from the therapeutic setting, boundary violations are those that are harmful and exploitative.

Boundaries, Boundary Crossings & Boundary Violations

Boundaries in therapy define the therapeutic-fiduciary relationships or what has been referred to as the "therapeutic frame." They distinguish psychotherapy from social, familial, sexual, business and many other types of relationships. Some boundaries are drawn around the therapeutic relationships and include concerns with time and place of sessions, fees and confidentiality or privacy. Boundaries of another sort are drawn between therapists and clients rather than around them and include therapists self-disclosure, physical contact (i.e., touch), giving and receiving gifts, contact outside of the normal therapy session, use of language, clothing and proximity of therapist and client during sessions (Zur, 2022).

Boundary violations and boundary crossings, while different, should be considered while assessing conflicts of interest. Boundary violations are unethical and harmful to clients. They happen when therapists are involved in exploitative relationships such as sexual contact with a client or an exploitive business transaction.

Boundary crossings are not unethical and can be therapeutically helpful. Examples include: flying in an airplane with a patient who suffers from a fear of flying, having lunch with an anorexic patient, making a home visit to a bedridden elderly patient, going for a vigorous walk with a depressed patient, or accompanying a patient to a dreaded but medically essential doctor's appointment to which he or she would not go on their own. Boundary crossings should be implemented according to the client's unique needs and specific situation. It is recommended that the rationale for boundary crossings be clearly articulated and, when appropriate, included in the treatment plan. Boundary crossings are normal, unavoidable and expected in small communities such as rural, military, universities and interdependent communities such as the deaf, ethnic, LGBT,

etc. Different cultures have different expectations, customs and values and therefore judge the appropriateness of boundary crossings differently. More communally oriented cultures, are more likely to expect boundary crossings, and frown upon the rigid implementation of boundaries in therapy (Zur, 2022).

Not all boundary crossings constitute dual relationships. Making a home visit, going on a hike, or attending a wedding with a client and many other 'out-of-office' experiences are boundary crossings which do not necessarily constitute dual relationships. Similarly, exchanging gifts, hugging, or sharing a meal are also boundary crossings but not dual relationships. However, all dual relationships, including attending the same church, bartering, or playing in the same recreational league, for example, constitute boundary crossings (Zur, 2022).

Dual Relationships

In the clinical social work profession, dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether in professional, social, or business interactions. Dual or multiple relationships can occur simultaneously or consecutively. Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries (NASW, 2021).

Zur (2022) Identifies multiple types of dual relationships which include:

Social dual relationship is where a therapist and client are also friends or have some other type of social relationship. Social multiple relationships can be in person or online. Having a client as a Facebook 'friend' on a personal, rather than strictly professional basis, may also constitute social dual relationships. Other types of therapist-client online relationships on social networking sites may also constitute social dual or multiple relationships.

Professional dual relationship is where a counselor and client are also professional colleagues in colleges or training institutions, presenters in professional conferences, co-authoring a book, or in other situations that create professional multiple relationships.

Special treatment-professional dual relationships may take place if a professional is, in addition to psychotherapy, also providing additional therapeutic services, such as progressive muscle relaxation, nutrition or dietary consultation, Reiki, etc.

Business dual relationships are where a therapist and client are also business partners or have an employer-employee relationship.

Communal dual relationships are where the therapist and client live in the same community, belong to the same church or synagogue, or where the therapist shops in a store that is owned by the client or where the client works. Communal multiple relationships are common in small communities when residents know each other.

Institutional dual relationships take place in the military, prisons, some police department settings and mental hospitals where dual relationships are an inherent part of the institutional settings. Some institutions, such as state hospitals or detention facilities, mandate that clinicians serve simultaneously or sequentially as therapists and evaluators.

Forensic dual relationships involve clinicians who serve as treating therapists, evaluators, and witnesses in trials or hearings. Serving as a treating clinician as well as an expert witness, rather than fact witness, is considered a very complicated and often ill-advised dual relationship.

Supervisory relationships inherently involve multiple roles, loyalties, responsibilities, and functions. A supervisor has professional relationships and duty not only to the supervisee, but also to the supervisee's clients, as well as to the profession and the public.

Sexual dual relationships occur when the therapist and client are also involved in a sexual relationship. Sexual dual relationships with current clients are always unethical and often illegal.

Digital, online, or internet dual relationships take place online on social networking sites, such as Facebook, Instagram or Twitter, LinkedIn or on blogs or chats, and they constitute unique dual or multiple relationships. These can be professional (i.e., on LinkedIn or Facebook pages), social (i.e., Facebook or other social media sites), or other types of multiple relationships that take place on chats, Twitter, blogs, etc.

Dual relationships can happen for a number of different reasons. While some are avoidable, others are not. Zur (2022) identifies the following instances where dual relationships might come about:

Voluntary-avoidable: Usually these dual relationships take place in large cities or metropolitan areas where there are many therapists, many places to shop, worship or recreate.

Unavoidable: Multiple relationships are often unavoidable in rural areas, sports psychology, drug and alcohol recovery inpatient, outpatient or 12 step programs, such as AA, and on Native American reservations. Supervisory relationships inherently involve multiple roles and multiple relationships, as supervisors have responsibility to the supervisee, the client, the community, and the profession at large. Dual relationships are sometimes unavoidable in institutions, such as mental hospitals.

Common - Normal: Dual relationships are common and generally normal among disabled groups, spiritual/faith communities, LGBTQI communities and in any small community within or nearby big metropolitan areas. Multiple relationships are a common part of universities and colleges as well as training institutions, such as psychoanalytic, cognitive-behavioral, somatic and other teaching institutions. Dual relationships can also be common within adventure therapy or nature therapy settings. As time goes by, we witness more acceptance of digital or online multiple relationships, primarily among young therapists and young clients who often tend to blur the line between therapeutic and social boundaries, especially in social media.

Mandated: These dual relationships take place primarily in the military, prisons, jails and in some police department settings. Inherent in these settings is that the mental health professional is mandated to have multiple accountability. At times, psychologists in forensic mental institutions are also involved in mandated multiple relationships (especially when ordered by a judge to serve in a dual role of evaluator and treater).

Unexpected: Unexpected multiple relationships occur when a therapist is not initially aware that a current client is also a friend, colleague, co-worker or even an ex-spouse of another client. Similarly, unexpected dual relationships take place when, unbeknownst to the psychotherapist, the client joins the therapist's church, book club, or baseball recreation league. Digital or online multiple relationships, including social networking or dating sites, can catch therapists by surprise.

While many of the above examples of dual relationships could be viewed as unavoidable, and will not violate the code of ethics of many professional associations (does not cause impairment, exploitation or harm) the one dual relationship that all groups agree is unethical is having a dual sexual relationship with a client. Not only is it unprofessional and unethical, but it is also often illegal.

Boundaries and Technology

There are ongoing concerns that ethical standards surrounding technology are constantly lagging behind the fast-paced progress of today's technology. It would be easy for most to produce a list of benefits and dangers of social media, both personally and professionally. The challenge for clinicians is to use the benefits and opportunities that social media enables, without causing harm and reflecting critically on their incorporation into everyday practice. Many practitioners utilize social media to publicize professional services. Social media enhances their capacity for career building when they are able to promote themselves as employable and professional. This is important for job-seekers, as many employers check a job applicant's personal websites and social media postings and use social networking sites for recruitment.

Some employees, including those in health and social services, have lost their jobs due to social media misuse or privacy breaches. Many practitioners have not considered the impact of their online material on service users and these can pose risks to them individually, their profession, and service users. Lack of clarity about what is permissible and what is not in online spaces gives rise to an "ethical gray zone" for clinicians. Blurred boundaries between public and private spaces online and social media sites' requirement that users agree to terms and conditions that allow for surveillance, data mining, and target marketing, with applications (apps) retaining users' details, conversations, and material they have shared privately create a wide-ranging audience for material posted on the internet (Boddy & Dominelli, 2017).

Professional Associations Stance on Dual Relationships

Though these dual relationships are generally frowned upon in ethics' codes, there is grace allowed for situations in which multiple relationships are inevitable as long as confidentiality and transparency with the patient are upheld. Based on the aforementioned standard, the crux of multiple relationships is the risk of harm to the

client and the impairment in the objectivity of the practitioner. However, the determination of these factors can be multilayered and nuanced when providers practice in areas in which the personal and professional often collide; such as rural areas and small communities (Lankster et al. 2019).

The American Association for Marriage and Family Therapy states: Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken (AAMFT, 2015).

The National Association of Social Workers says that its professionals should be alert and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client. Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests. Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.) (NASW, 2021).

Finally, the American Psychological Association asserts that a psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists. Multiple relationships that

would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical (APA, 2017).

Decision Making Process for Dual Relationships

Clients need to be assessed on an individual basis, and the uniqueness of each case must be considered when delving into multiple relationships with clients. Of utmost importance, however, is the therapeutic professional judgment when considering what is in the best interest of the client, and when determining the extent to which boundaries can be pushed. In rural communities, unless the counselor leads a solitary life, interactions outside the therapeutic relationship are fated to happen. Chance meetings when one is shopping, exercising, and dining out, and more anticipated meetings such as memberships to the same organizations and associations such as church and school are inevitable. Beyond these are the business relationships and friendships that form in professional and social environments in rural communities. When assessing what is in the best interest of each client, his/her vulnerabilities must be considered, including the context of the therapy and the intimacy of the extended interactions with the therapist. These considerations will help to determine the overall harm and benefits that developing multiple relationships have regarding the best interest of the client. The experience and competence of the counselor to manage numerous relationships without violating boundaries and without causing harm to the client is crucial (Goodine, 2017).

When there is potential for a dual relationship, therapists must take precautions to ensure judgment is not impaired and that clients are not exploited. Behavioral health professionals who are concerned that a therapeutic relationship is headed in a dangerous direction can address those concerns by seeking consultation and/or supervision to determine whether they can continue to provide treatment that will be effective for the client and in the client's best interest (Jasper, 2018).

The burden of proof that the dual relationship does not cause harm is on the therapist.

Considerations for boundary setting and boundary crossing in the context of therapy from Zur (2022) include four components:

Client factors: Culture, history (including history of trauma, sexual and/or physical abuse), age, gender, presenting problem, mental state and type and severity of mental

disturbances, socio-economic class, personality type and/or personality disorder, sexual orientation, social support, religious and/or spiritual beliefs and practices, physical health, prior experience with therapy and therapists, etc.

Setting factors: Outpatient vs. inpatient; Solo practice vs. group practice; Office in medical building vs. private setting vs. home office; Free-standing clinic vs. hospital based clinic; Privately owned clinic vs. publicly run agency; The presence or proximity of a receptionist, staff or other professionals. It also includes Locality: Large, metropolitan area vs. small, rural town vs. Indian reservation; Affluent, suburban setting vs. poor neighborhood vs. university counseling center; Major urban setting vs. remote military base, prison or police department setting.

Therapy factors include the following two components:

1. **Therapeutic factors, such as modality:** Individual vs. couple vs. family vs. group therapy; Short term vs. long term vs. intermittent long-term therapy; Intensity: Therapy sessions several times a week vs. once a month consultation; Population: Child vs. adolescent vs. adult psychotherapy; Theoretical Orientation: Psychoanalysis vs. humanistic vs. group therapy vs. body psychotherapy vs. eclectic therapy.

2. **Therapeutic relationship factors:** Quality and nature of therapeutic alliance, i.e., secure, trusting, tentative, fearful or safe connection. Intense and involved vs. neutral or casual relationships; Length, i.e., new vs. long-term relationship; Period, i.e., beginning of therapy vs. middle of therapy vs. toward termination; Idealized/transferencial relationships vs. familiar and more egalitarian relationships; Familiarity and interactivity in the community vs. only in the office, distanced relationship; Presence or absence of dual relationships and type of dual relationships, if applicable.

Therapist factors: Culture, age, gender, sexual orientation; Scope of practice (i.e., training and experience).

Once all the above has been considered Zur (2019) makes the following decision making recommendations:

- Develop a clear treatment plan, which is based on client's problems, needs, personality, situation, venue, environment and culture.

- Conduct a risk-benefit analysis before crossing boundaries.

- In planning to cross a boundary or enter into a dual relationship, consider the welfare of the client, effectiveness of treatment, avoidance of harm/exploitation, conflict of interest and the clinical impairment.
- Consult with well-informed, open-minded and non-dogmatic consultants, clinical, ethical or legal experts in complex cases before crossing intricate boundaries or entering into complex dual relationships. Document the consultations well.
- Attend to and be aware of your own needs through personal therapy, consultations, conversations with friends, supervision or self-analysis.
- Do not let fear of lawsuits, licensing boards or attorneys determine your treatment plans or clinical interventions. Act with competence and integrity while minimizing risk by following these guidelines.

Any potential dual relationship should be documented in a client's file. The file should include information about how a situation with a client was handled, information about the consultation or supervision received, and the rationale for any decisions made. A well documented file will be helpful in the event a patient or third party files a complaint (Jasper, 2018).

Clear Boundaries to Avoid Unethical Behavior

Clinicians should have a clear informed consent that addresses dual relationships and expectations, including: how the therapist communicates with clients outside of sessions; the types of topics that the therapist prefers to address during sessions as opposed to via phone calls, emails and texts; the therapist's hours of operation and when clients can reasonably expect the therapist to respond to communications from the client. By discussing these issues at the outset and setting firm parameters, therapists will avoid the potential for the kinds of interactions that may compromise the integrity of the therapeutic relationship (Jasper, 2018).

A common understanding of the therapeutic relationship and the boundaries thereof is developed at the start of treatment. When providing services to individuals with whom one has a multiple relationship. it is imperative to create mutual boundaries to contain the therapy while considering the implications of the dual relationship. These boundaries should be constructed in a manner that is befitting the cultural norms of the

community, protect the patient, and permit practitioners to place distance between their personal and professional lives. With regard to cultural norms and traditions, the closeness of a small community generally breeds familiarity and a family-like social environment. Residents often casually greet one another and attend at-larger community events tinged with a socially intimate ease. As such, it may draw more attention for a therapist to not casually speak or to actively avoid a client outside of the office. Alternatively, the responsibility of effectively maintaining multiple roles as provider and co-community member can increase the chances of practitioner burnout. Therapists may set boundaries such as not engaging in extended conversation with the client outside of therapy, and/or not discussing out of office interactions within therapy. No matter the terms, a plan for navigating the norms of the community while maintaining the container of therapy should be created at the outset of therapy, stringently upheld by the provider, and revisited and revised as needed throughout the treatment. Practicing in a close-knit community requires a level of adaptability that is often not necessary in other settings. This flexibility also encompasses a significant level of vigilance and self-awareness on the part of the practitioner. On your feet, thinking and self-awareness enables the clinician to quickly and effectively navigate the various social and professional situations inherent to multiple relationships. The compass for navigating this adaptability is the reduction of the dual relationship (Lankster et al. 2019).

Unethical Dual Relationships & Sexual Misconduct

Dual relationships that impair professional judgment, exploit, and harm clients are illegal, unethical, considered unprofessional conduct, and may be grounds for revocation of a licensure or registration (Jasper, 2018).

Unethical dual relationships may include: borrowing money from a client, hiring a client, engaging in a business venture with a client, engaging with a close personal relationship with a client. This would also extend to a client's spouse or partner or family member.

Sexual intercourse, sexual contact or sexual intimacy with a patient, or a patient’s spouse or partner, or a patient’s immediate family member is unethical. Depending on one’s professional licensure this may only include while the person is an active client with the therapist, it may be for two years post being an active client, or it may be deemed unethical indefinitely if the person was ever a client. It is up to clinicians to know and

follow their specific ethical expectations for their professional associations code of ethics and the licensing body in the state in which they are licensed to practice.

In California, the minimum penalty for sexual misconduct with a client is 120 to 180 days actual suspension during which time the therapist would be required to undergo a psychological or psychiatric evaluation. The therapist would also be required to take and pass the licensure exam before being allowed to resume the practice of psychotherapy, be on probation for 7 years, and only be able to practice under supervision. The board would be able to recover the costs of administering probation (currently at $1,200 a year). The maximum penalty for sexual misconduct is revocation or denial of a license or registration and cost recovery. A therapist who is found to have intentionally or recklessly caused emotional harm to a client would, at a minimum, undergo a 90- to 120-day suspension, five years probation, a psychological or psychiatric evaluation, psychotherapy, and could only practice if under supervision. The Board would have the discretion to revoke or deny a license or registration and impose cost recovery. For psychotherapists who are CAMFT members, these types of offenses may also result in an investigation by CAMFT's Ethics Committee (Jasper, 2018). Many states and licensing boards have similar legal consequences.

Addressing Attraction to Clients

The American Counseling Association's and the American Mental Health Counselors Association's Code of Ethics are both clear that sexual/romantic relationships with current clients, clients' partners, and/or family members are prohibited. However, this admonishment has had little effect on actual outcomes. According to the CNA and Healthcare Providers Service Organization 2019 report on counselor liability claims, 43.9% of all closed professional liability claims in a 5-year period fell under the following: sexual/romantic relationships with current clients or their partners/ family members, sexual or romantic relationships with current supervisees, multiple relationships with clients, and sexual relationships with former clients or their partners/family members before the ethically mandated 5-year period had elapsed (Jacob, et al, 2022).

Counseling is inherently about the interpersonal dynamics between counselor and client, and sexual attraction is especially plausible in relationships characterized by connection and vulnerability. Jacob et al (2022), make the following recommendations for when counselors find themselves attracted to a client.

- **Expect Feelings of Attraction, Including Sexual Attraction:** When counselors experience attraction to a client - romantic, sexual, or otherwise - the recommendation is to refrain from blame or overwhelming shame and remember that few counselors enter the profession with the intention of becoming attracted to their clients.

- **Do Not Act on the Attraction and Do Not Disclose It to the Client:** Boundary violations do indeed happen. This is the ultimate abuse of power in the counselor-client relationship, with a storied history of evidence suggesting this is a direct route to professional deterioration and serious consequences for both the counselor and the client. It is not recommended that counselors share these feelings with the client. Evidence suggests this places an unnecessary burden on the client and is likely to be for the counselor's own gratification rather than benefiting the client.

- **Balance Your Reaction:** Counselors should recognize that normalizing feelings of attraction does not mean dismissing, minimizing, or ignoring these feelings, and that such occurrences are a normal part of the counseling process that can be resolved. It is recommended that when counselors identify that attraction is occurring, they should spend time in supervision and personal reflection identifying the attraction's meaning and etiology. With the client, however, they should carefully monitor all actions in sessions and ensure they are in keeping with the ethics of the profession.

- **Do Not Handle It Alone:** Rather than letting secondary feelings such as embarrassment, guilt, shame, excitement, or disgust be a barrier to processing and reflecting, counselors should consult with a supervisor, mentor, or colleague.

- **Make Use of Emotion Regulation Strategies:** Emotion regulation is the intrinsic or extrinsic process of monitoring, evaluating, and making efforts to modify emotional responses. Counselors utilizing this strategy are trying to be aware of their own feelings by viewing them through the lens of ethics, and regularly questioning whether their feelings may lead to harmful or unethical behavior.

They go on to discuss how to address when a client discloses they are attracted to the counselor, their recommendations include (Jacob et al, 2022):

- **Be Supportive of Exploration:** Clients have been professing attraction to their counselors since the profession's inception. The goal should be to emphasize

appropriate boundaries, but also to allow clients space to explore their experiences.

- **Explore Your Own Emotional Response (Both in the Moment and in Supervision):** As with any difficult situation in the counseling relationship, building self-awareness via reflective practice is recommended. Though it is recommended that counselors refrain from excessive reflection in the session, their response to this disclosure should be logged mentally in the moment for later reflection and (if applicable) for discussion in supervision.

Reporting Violations

Most professional associations expect that if clinicians suspect a colleague of unethical behavior that they bring it to that person's attention and attempt to resolve the issues. If such an informal resolution is inappropriate or unsuccessful to resolve the issue and the ethical violation has substantially harmed or is likely to substantially harm an individual or organization, further action can be taken. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities (APA, 2017).

Additional Considerations

Other considerations of how a dual relationship might impact the therapeutic relationship include (GoodTherapy, 2019):

- There is a lack of objectivity: For example, if therapists were to treat an influencer they follow on social media, their admiration of the client may skew their clinical judgment.

- The boundary between roles is unclear: If a client and therapist are friends, they may inadvertently begin to discuss mental health issues outside the office.

- There aren’t any guidelines for when therapy will end: A client may be reluctant to terminate therapy with a close neighbor for fear of awkward encounters later.

- The difference in power makes it easy for the therapist to potentially harm the client: The therapist is also the client's teacher and can give the client a bad grade.

Avoiding all dual relationships keeps therapists in unrealistic and inappropriate power positions, increasing the likelihood of exploitation. The prohibition of benign dual relationships leads to increased isolation, which has several serious ramifications (Zur, 2022):

- Isolation can increase the chance of exploitation of clients by therapists.
- Isolation in therapy may reduce effectiveness because client's difficulties, which were often caused by familial/childhood isolation, often cannot be healed by further therapeutic isolation.
- Isolation forces the therapist to rely on the client's report as the main source of knowledge. Therapeutic effectiveness can be diminished by excluding collateral information and by exclusive reliance on a client's subjective stories.
- Introducing appropriate dual relationships may alter the power differential between therapists and clients in a manner that can facilitate better health and healing.

Case Studies

Case Study 1

Roger has been seeing Leo, a popular 15 year old student-athlete for six months. Leo is grieving over the loss of his father, a 48 year old in the late stages of ALS. Leo was referred to therapy when he began to lose interest in school and sports, started experimenting with drugs and alcohol, and was feeling depressed and anxious. One day Leo comes to his session excited and animated because he has been invited to try out for a well-respected traveling basketball team. Roger becomes anxious when he realizes that Leo is trying out for the team that his own son is on. While he is happy for Leo and thinks this could be a very positive experience for him, he is concerned about the possibility of entering into a multiple relationship with Leo if he makes the team, as the

team commitment will involve seeing each other outside of the office, traveling out of town for tournaments, and regular interactions between Leo and Roger's son.

Case Analysis 1

In the above scenario, the issue of multiple roles/dual relationships is presented to Roger without any intent on his part to create the situation. Although Roger is contemplating what the best course of action is as he is faced with his professional, personal, and community role, he doesn't feel the need to process anything with Leo until he finds out if Leo has made the team. He knows that he and Leo have made positive steps toward dealing with Leo's grief and loss, and has no intention of abandoning Leo in the therapeutic process. He also knows that he must consider confidentiality and boundary issues if he is going to see Leo outside of the office. Multiple relationships that do not cause impairment, risk exploitation, or harm are not unethical and often, especially in rural communities, inevitable and unavoidable (Zur, 2019).

Every dual relationship and situation is unique and requires careful consideration. The following questions designed for clinical social workers are helpful to consider for all behavioral health professionals (NLASW, 2018):

- Is the dual relationship avoidable or unavoidable? If unavoidable, what steps can be taken to minimize risk?
- What is the nature of the professional relationship? Does the context of practice make a difference?
- Is the relationship having an impact on one's objectivity and decision-making?
- Whose needs are being met by the dual relationship? Social worker or client?
- Is this creating a blend between one's personal and professional life? Does this result in a conflict of interest (actual or perceived)?
- Could client confidentiality be compromised?
- Are exceptions being made for one client? If so, why?
- What policies, standards, or ethical values are applicable to the situation?
- How might this dual relationship be perceived by one's social work colleagues,

employer, or community members?

- Are there cultural elements that need to be considered?
- What options are available for addressing the dual relationship? (NLASW, 2018).

If Leo gets selected for the traveling team, Roger will want to look at the above questions to help determine with Leo whether or not to continue therapy. It may be a great opportunity to empower Leo with some of the decision-making, such as how to manage the situation when they see each other away from the office. Roger will also want to consider how his own son may be impacted by the dual relationship. Finally, Roger may initially choose to continue to see Leo if he feels it is in Leo's best interest or may feel that he needs to adhere to NASW ethical standards which state, "protecting clients' interests may require termination of the professional relationship with proper referral of the client." When and if they determine that they should terminate therapy, Roger will need to make an appropriate referral.

Case Study 2

Marianne is a divorced clinician who has been in practice for 14 years. One night when she is out with her girlfriends, she runs into a former client, Tommy. She first met Tommy about three years ago when he and his teenaged son came to see her about relationship difficulties they were experiencing. Marianne worked with Tommy and Adam for approximately three months, until the relationship improved and all parties agreed to terminate therapy. Tommy has been divorced for four years. When they see each other at the restaurant, Marianne and Tommy talk briefly. She learns that Adam is away at college and that he and Tommy have been doing well overall. She does not really think anything about it until he calls her the following week to ask her out to dinner. Marianne tells Tommy that she will have to think about it, and agrees to call him back later in the week. While Marianne feels some attraction toward Tommy and knows that it has been over two years since their last professional encounter, she also wants to think about all the ethical considerations that would come into play if she were to date and pursue an intimate relationship with Tommy.

Case Analysis 2

While professional codes of ethics have specific guidelines for sexual intimacy with former clients, there are also other issues in this scenario that Marianne would want to

consider, including:

Unfair advantage - Is Marianne taking unfair advantage of the relationship she had with Adam if she chooses to enter into a personal relationship with his father?

Integrity - It is a good moral decision to enter into a personal relationship with Tommy, even though time has passed? Would she be behaving in a trustworthy manner?

Multiple relationships - Does entering into a personal relationship with Tommy create a situation of exploitation or potential harm, and will the influential position that she had as the clinician carry over and create an unhealthy dependency?

Sexual Relationships - According to the NASW Code of Ethics, social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers, not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship, assume the full burden for setting clear, appropriate, and culturally sensitive boundaries (NASW, 2021). According to the AAMFT Code of Ethics, "Sexual intimacy with former clients or with known members of the client's family system is prohibited" (AAMFT, 2015).

Can Marianne be assured that establishing a personal relationship with Tommy will not in any way exploit or cause injury to Tommy or Adam?

Seek assistance - Will Marianne seek consultation from other professionals to discuss this issue?

If, after considering the above factors, Marianne decides to date Tommy, the onus will be on her to demonstrate that there has been no undue harm to Tommy or Adam. Marianne should document the process and ensure that the appropriate precautions are taken to establish that she has acted thoughtfully and with care.

Conclusion

Having ethical standards and guidelines in behavioral health professions cannot in and of itself guarantee ethical behavior. Such standards can guide practitioners who encounter ethical challenges and establish norms by which professional actions can be judged. In the final analysis, however, ethical standards in general, and a code of ethics in particular, are only one part of clinicians' ethical arsenal. For example, in social work practice, in addition to specific ethical standards, social workers need to draw on ethical theory and decision making guidelines; social work theory and practice principles; and relevant laws, regulations, and agency policies. Most of all, social workers need to consider ethical standards within the context of their own personal values and ethics (Reamer, 2018). These considerations may be applied to other behavioral health professions as well.

The keys to navigating dual relationships are utilizing an appropriate decision-making model, transparency, the setting of boundaries during the informed consent process, and flexibility. If properly managed, a dual relationship does not have to hinder therapeutic outcomes. On the contrary, this relationship may serve to benefit the client in unexpected ways (Lankster et al. 2019).

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