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# Ethics in Clinical Practice: Dual Relationships and Boundary Crossing



# Dual relationships and boundary crossing: A critical issues in clinical psychology practice

The issue of boundary and dual relationship has been a major subject of concern in psychological practice. Ethics complaints on dual relationship and boundary crossing continue to rise both in nature and variety. This paper examined and shed light on the complexities surrounding dual relationship and boundary crossing in clinical psychology by explaining the pertinent moral and clinical worries that clinical psychologist's face daily in their practice. To achieve the objectives, the paper analysed underlying themes: 1) using empirical review of relevant literature to identify clinician's attitudes toward risky and useful dual relationship and boundary crossing in clinical practice, 2) to learn whether involving in dual relationships negatively or positively influences therapeutic outcome, 3) analyze the concept, challenges and differences associated with dual relationship in clinical practice using decision making model, and 4) come up with strategies that help clinical psychologists to make flawless ethical standards as well as offering of moral *guidance*. Finally, the study suggests that, though dual relationship sometimes enhances therapy, aids treatment strategy, and promotes positive relationship between clinician and client, it also weakens the treatment process, hampers the clinician-client cooperation, and brings instant or lasting damage to the service user.

## INTRODUCTION

The issue of boundary and dual relationship has been a major subject of concern in psychological practice in recent time. In fact, psychology and other mental health professionals have grown increasingly concerned about "dual relationship," in clinical practice including the boundary crossing and boundary violation. Of most

concern is that, the issue has developed in the context of professionalization to say the least. No time in the history of psychology profession has the ethics of professional conduct being questioned or confronted with a wide range of contemporary ethical problems like it is today in our society. The profession has been besieged with clear

messages about the immorality and negativity of dual relationship and boundary crossings, to the extent that the values and moral foundation of the psychology discipline was seriously challenged both by clients and consumers.

For instance, from the psychology course guidelines, to literatures on moral values, and clinical internships, it has been labelled as inappropriate, if not unprofessional for clinical psychologists to get involved in the following circumstances: unofficial work or private relationship with clients, taken gifts offer, engage in physical contact and last but not the least, socialize with clients in their practice. This position also received plaudit from large number of researchers, who one way or the other have made massive contributions in the area of study, particularly as regard to boundary crossing and dual relationships (Corey, 2009).

In fact, most evidence suggests that, in most cases, client's faces higher risk during treatment due to negativity of dual relationship. Professional training also highlighted that boundary crossing is likely to affect clients 'right and also causes unjust sexual contacts. Though this is reported as immoral and often linked to abuse and harm, its continuous existence in clinical practice remains an issue of concern till date. Similarly, health professional associations obligated their members to respect and uphold ethical standards and codes of conduct that guides, regulates and protect clients from experiencing bad practices. Therefore, for a clinical psychologist, navigating through an ethical practice is a difficult mountain to climb.

Also, psychologist and clients are regularly hindered by uncontrollable circumstances that prompt porous boundary between therapeutic and social relationships.

Additionally, earlier reports gave special consideration to issues that are scientifically related to beliefs and behaviours about boundaries. Among the problems that emerged from these studies include: therapist sexual category, career (psychiatrist, psychologist, social worker), knowledge, marital status, practice situation (private or public), locality, client sexual category, (such as solo or group private practice and outpatient clinics), practice area (size of the community), and last but not the least, theoretical belief.

Surprisingly, the corollary assertion is the religious and community beliefs about the issue, particularly the way they stuck with the prospect of relationships concept in clinical practice (Catalano, 1997; Doyle, 1997; Sidell, 2007). Despite all the aforementioned challenges, it is important to state that research on boundary crossing continue to provide guidance to difficult issues that clinicians come across as they make judgement on certain ethical issues in clinical practice. The question is, how can we as psychologist blend our professional roles and personal needs without compromising our profes-

sional responsibilities?

## **Purpose**

Clinicians often miss the mark or fail to understand the possibility for dual relationships, particularly, how to cope with relational dilemma in clinical practice. This problem remains an issue in clinical practice till date. This paper examines and sheds light on the complexities of dual relationship and boundary crossing in clinical psychology and explains the pertinent moral and clinical worries that clinicians faces in their practice. The paper also looked at how dual relationship influences decision making process in clinical practice. To achieve this, the paper focuses on five underlying themes: 1) makes a distinction between the following factors: risky boundary violations, useful boundary crossings and inevitable or caring dual relationships, 2) used an empirical review of relevant literature to identify clinician's attitudes toward risky and useful dual relationship and boundary crossing, 3) observed whether involving in dual relationships during clinical practice has any negative or positive influence on therapeutic outcome, 4) used the decision making model to address the concept, challenges and variances associated with dual relationship in clinical psychology and 5) come up with strategies that help psychologists to make flawless ethical standards and offer moral guidance regarding dual relationships.

## **LITERATURE REVIEW**

### **Dual relationship and boundaries in clinical practice**

As we all know, psychology profession strives to promote the emotional well-being and social welfare of others. However, events in recent time continue to point towards its utmost scrutiny. Clinical psychologist faces daily challenges by handling the issue of dual relationships and boundary crossing without compromising their professional conduct and practice. In facts, earlier research, particularly in the 80s and 90s demonstrated how hypothetical orientation, community size, psychoanalyst sexual characteristics, client sexual category, occupation, and other issues impact psychology profession, particularly on the issue of nature and suitability of borderline crossings in clinical practice. Besides, the period between the 1980s and 1990s also witnessed a practical outburst of healthy argument and considerable works on dual relationships, bartering, companionable touch, out of office consultation and other nonsexual boundary matters to mention a few in clinical practices.

Also, thought-provoking and considerable literature on dual relationship in clinical psychology observed a constructive and undesirable aspect of boundaries and

boundary crossings. A typical example of this is the article published by American Psychologist in 1992 requesting for drastic changes in the ethics code of the profession. This publication further showed lack of clarity and awareness on when and how clinicians should engage with clients. To buttress this position, the Committee on Ethics of the American Psychological Association in their report suggested that around 40 to 50% of the complaints received during the period of 1990 to 1992 are on dual relationship. Also, Sonne (1994) reported that, of all the problems facing APA members, the issue of dual relationship was the most common reason for their membership termination. Unfortunately, as a result of the ambiguity attracted, the concept continues to face serious litigation and disciplinary cases, such as ethics committee hearings, and complaints to professional boards of licensure. Research sees boundary crossings as a well-fashioned treatment strategy that increases the therapeutic success (Lazarus and Zur, 2002). For instance, the recent APA Code of Ethics of 2002 offered a new insight into the issue of boundary crossing by stating that, "Psychologists ordinarily refrain from bartering", that was in the 1992 code, and incorporate a new sentence, "Multiple relationships that would not rationally be expected to cause impairment, risk exploitation or harm are not unethical" (APA, 2002, section 3.05), to the multiple relationships unit.

In addition, the dual relationship also focused on role theory. That is, the issue of social roles that covers innate anticipations about how somebody in a specific role should conduct himself or herself, along with the rights and responsibilities that go along with the functions needed to be addressed. Psychology profession uses ethical principles to advance moral code and moderate professional behaviour of their members (Beauchamp and Childress, 1994). To buttress this assertion, the code of conduct of the American Psychological Association, ethical principles (APA, 1992) recognized "multiple dealings". According to the code of conduct, it is not being possible or sensible in particular circumstances, "for psychologists to evade other non-professional interaction with their clients" (p. 1601). However, going into such interactions might prejudice the psychologist's fairness; hinder their professional practice or abuse the other party" (p. 1601).

Moreover, other health professionals also incorporated in their ethical guidelines, principles and practice that regulated and contained dual relationships in clinical practice. Yet, conflicts arise when the beliefs and expectations linked to one role call for the conduct that is unsuited of the other role (Kitchener, 1988). Dual role relationship happens when a particular person or an individual concurrently or successively partakes in double role (Kitchener, 1986). This definition is supported by

Carroll et al. (1985), where they established that in addition to the professional rapport, the clinician created some other rappers with the person: colleague, relative, student or business partner. Despite all these challenges, further research and literatures on boundary and dual relationship are needed to aid and change our thoughts and knowledge about boundary crossing in clinical psychology. Therefore, the question is: what and what should be prohibited or condoned when working with clients? Which of the boundary crossings were therapeutically helpful and harmful? And what therapeutic methods are acceptable or not acceptable for certain culture or communities?

### **Boundary crossing and violations in clinical practice**

Logically and practically, not all boundary crossings were harmful to clinical work. Studies in Europe and the US demonstrated that dual role relationships can be neither harmful nor helpful to clients and therapist (Edwards, 2007; Kitson and Sperlinger, 2007; Lazarus et al., 2004; Pugh, 2007). Research also maintained a distinction between boundary crossing and violations in clinical practice (Remley and Herlihy, 2009). Literature on ethical issue in clinical practice found that boundary violations are more injurious to clients, whereas, some boundary crossing is beneficial (Knapp and Slattery, 2004). As a consequence, professionals must endeavor to always differentiate between conducts that are boundary cross and those that are boundary violations. Also, the APA Code of Ethics of 2002 made some clarification that prevents authorities, courts and ethics committees from employing the logical or community yardstick to evaluate non-logically oriented psychologist, who embraced boundary crossing interventions in a society where dual relationship and boundary crossing are inevitable. On the other hand, some school of thought, such as the behavioural, and humanistic, sees supportive boundary crossing that is client's focused oriented (Lazarus, 1994; Williams, 1997) as predicting positive therapeutic outcomes. In addition, a body of psychology literature (Roth and Fonagy, 1996; Hubble et al., 1999) also suggested positive therapeutic outcome as a correlation of clinician-client relationship. For example, Roth and Fonagy (1996) and Hubble et al. (1999) also found that client variables and extra-therapeutic elements are responsible for the 40 percent of progress made in therapy, while 30 percent are accounted for the therapeutic relationship.

Consequently, a dual relationship happens when there were multiple roles or external relationship between a clinician and a client (Bleiberg and Skufca, 2005; Moleski and Kiselica, 2005; Ringstad, 2008). This include: business, social, communal, familial, sexual, and professional oriented to mention a few (Nigro, 2004). A dual role

relationship is also classified into two types: sexual and non-sexual (Corey et al., 2007). Corey et al. (2007) linked sexual dual-role relationships with negative outcomes. They found that such relationship is the probable cause of harm to client's emotional and social wellbeing. These interactions are categorized as harmful and can lead to bigger potential for negative outcomes (Bleiberg and Baron, 2005; Kolbert et al., 2002; Reamer, 2003). Though this is not made equal, they are structured this way in this paper in order to distinguish the degree of harm they bring to clients.

Similarly, research on dual relationship emphasized more on sexual misconducts between client-therapist (Gutheil, 1989, Corey et al., 2007) and less on other complex boundary crossings that are less noticeable but pose difficulties for clinicians. Empirical evidence on dual relationship found that boundary violations often go along with or lead to sexual misconduct (Corey et al., 2007; Gutheil and Gabbard, 1998). It was also established that abuses themselves do not constantly institute misconduct or misdemeanours or even bad method. While most psychologists believe they have a better understanding of boundary issues, using it when working with clients remains difficult. It was even worse when we look at the difficulty posed by the legal system, particularly, the complainants' lawyers, who see any act of boundary crossing as immoral, flawed, and injurious to their clients. This upshot is considered to be inherently harmful and consistently inhibit and undermine clinical practice (Epstein and Simon, 1990; Simon, 1992). Therefore, dual relationships are intrinsically dangerous and clinicians must endeavour to prevent it during practice.

In addition, many definitions were used to explain dual relationship in clinical practice. Some of these definitions are recognized by functions (Doyle, 1997; Edwards, 2007; Kitson, 2007; Nigro, 2003), while some by interpersonal closeness (Pugh, 2007). Functional interactions are defined as a situation where clients have an outside contact with a clinician in shared or professional means like community or business affiliation. In this circumstance, dual relational role happens when service users and clinicians developed external relationships or connection that was outside professional practices. The former can happen without the service users and clinicians' knowledge; while the latter grows with the understanding of the clinician (Borys and Pope, 1989). This, according to the American Associate for Marriage and Family Therapy (2001), builds and promotes abuse. Therefore, clinicians must look-for a way out by taking safety measures when working with clients. In addition, psychoanalytic theory highlights the significance of boundaries and the unbiased position of the clinician.

According to the theory, active and proper management of transference and other therapeutic process need a flawless and reliable boundary that allows the clinicians

to sustain the analytic setting of therapy (Langs, 1988). Like many other ideas in clinical practice, i.e., "therapy," "transference," and "association," this concept is closely linked when observed.

Of most importance is that, clinical psychologists must strive to understand and take into cognisance the three values that govern the relationship between boundaries, boundary violations, boundary crossings, and sexual misconduct. To start with, sexual misconduct starts with slight boundary violations. This showed an upsurge incursion into the patient's space and culminates to sexual contact. Gabbard (1989) and Simon (1989) found that the act of engaging in sexual misconduct takes the following sequence: moving from calling each other the last-name to the first-name; engaging in the personal or private discussion that hampers professional duty, involving in body contact i.e., pats on the shoulder, massages, and hugging each other; outdoor outing; sessions at lunch; having dinner together, going for movies and any other social event together; and last but not the least engaging in sexual intercourse. However, not all the act of boundary crossings or violations promotes or signifies sexual misconduct. An act of boundary violation of one professional ideology may be a normal professional practice for another. For instance, a "Christian psychiatry movement" might encourage clinicians to attend church service with one or more clients, while some permit an inherent boundary violation that supports employing clients in therapy by using them for experiment treatment setting. Though, negative training, messy practice, lapses of judgment, unconventional treatment ideas, and social-cultural condition are all revealed as promoting boundary violation in clinical practice, they are not necessarily predictors of sexual misconduct or action that pushes professional away from the principle and standard of care. Despite all this, the fact still remains that professional ethics committee, criminal juries, regulating boards, to mention a few, still see boundary violations or crossings as a probable evidence of sexual misconduct.

Lastly, from historical perspectives, some psychology school of thought favoured an inflexible boundary crossing or violation. For instance, studies found that some professional therapeutic leaning permitted inflexible boundaries using Freud as an example. This school of thought illustrated how Freud himself occasionally sent cards to his clients, borrowed them books, gave out gifts, discussed his personal life with clients, ate with them while on vacation, carried out outdoor analysis and last but not the least, analysed his own biological daughter. This, according to Gutheil and Gabbard, formed the basis for emerging research on "explorations," and developmental framework on boundary crossings and violations, and echoed its authentication in clinical practice. Gutheil and Gabbard (1993) found that judgments must be based



on the following situation and specifics: If exploration is to be beneficial, professionals should accept the resolution that "boundary crossing" is a descriptive word, neither admiring nor disapproving.

Therefore, judges should determine the effect of a boundary crossing on individual basis with emphasis on context and situational-facts like probable harmfulness of the violation to the client. A violation, then, represents a harmful crossing, a transgression, of a boundary (p. 190). Gutheil and Gabbard (1993) also looked at boundary crossing and violations from the context of role, time, place and space, money, gifts, services, clothing, language, self-disclosure, and physical contact to mention a few. Though they underlined the fact that border crossing sometimes is salutary, neutral, and harmful", they also concluded that the nature, clinical effectiveness, and influence of a particular crossing "can be measured through systematic consideration of the clinical environment" (pp. 188-189). This argument confirms that psychology profession is still confronted with how to handle and resolve boundary crossing and dual relationship in clinical setting. It also takes into consideration, both the theoretical orientation and contextual situation of both the client and the clinician. Although this issue was later addressed some years later by Gutheil and Gabbard (1998) in their article titled "Misuses and misunderstandings of boundary theory in clinical and regulatory settings"

### **Boundary decisions in context**

Although boundary decision is a weird and forbidding part of clinical practice, it requires a specific guideline and decision that is different from the general code of conduct of clinical profession. The theoretical momentous recorded in the literature provided a basis for clinical psychologists to decide whether or not it is appropriate for them to cross a particular boundary with client at a particular time and for a specific purpose. This can be achieved when we carefully observe and analyze the following factors: the therapeutic context, the clinician, and lastly the client to mention a few. But then, the decision taken should be based on a holistic approach to ethics. This sound very difficult, if we consider factors, such as the intense focus, the historical arguments, and the doubt and worry that follows the boundaries decision. Although boundary decision is a weird and forbidding part of clinical practice, it requires a specific guideline and decision that is different from the general code of conduct of clinical profession. Therefore, approach to boundaries as professionals should base on our attitude to ethical decision-making. Moreover, research shows that people, sometime, do not perceive their actions as having negative implication on others (Rest, 1983). Thus, this paper

revised the following basic assumptions about the ethical awareness and decision-making from ethics literature (Koocher et al., 2008; Pope and Vasquez, 2007).

1. As a clinician, ethical consciousness is a constant process that contains constant probing and individual obligation. For instance, conflicts with managed care companies, the intensity of clients' needs, the likelihood of formal criticisms of clients or condemnation by professional co-workers about boundary decision taken, mind-deadening procedures undertaken in the course of our duties, exhaustion, just to mention a few, can have adverse effect on our individual awareness and cloud our sense of personal obligation. These factors, if not properly considered, can overpower, drain, divert and lure professionals into ethical slumber. It also makes professionals more vulnerable to the extent that people around us will start questioning our ability and decision making.

2. Consciousness of professional codes and ethics is a vital feature of critical thinking and ethical decisions. Our professional codes and values enlighten rather than control our ethical judgments. As psychologists, we cannot substitute this for our emotion and thinking when we face ethical challenges. At the same time, they cannot defend us from ethical tussles and doubt that confront us daily as professionals. Besides, we should understand and appreciate individual uniqueness, particularly among clients and therapist, irrespective of their similarities. We should also appreciate the fact that every situation is unique and constantly evolves; In addition, we should understand that our professional inclination coupled with contextual factors such as community belief, client's orientation, and culture influences our perception of ethical decision.

3. The knowledge about the emerging profession and scientific theory and research is another vital feature of ethical competence. Therefore the assertions and conclusions from research should not be inactively acknowledged or automatically applied irrespective of their popularity and acceptability. We must receive published statements and recommendation with active and complete enquiring.

4. Though majority of psychologist and counsellors are reliable, devoted, thoughtful individuals, and dedicated to high ethical standards, none is infallible. As humans, we are all prone to mistakes in our professional duties. We sometimes overlook things that are important, make wrong choices, work from limited viewpoint, make a wrong conclusion, and have a strong view about things that are unwise. To address these problems, professionals should endeavour to always examine and assess their judgement, i.e., "What if I'm wrong about this? Is there something I'm not seeing? Is there any other way to approach this situation? Is there any other effective or

creative way to answer?"

5. As psychologists, we often find it easier to query the ethics of others -- particularly in a tough and contentious area like boundaries, while placing our own opinions, expectations, and actions out of bounds. For us to query the other colleague's ethical decision, we must also question our own decision and conduct and be ready for others to question us. That is, we must take it as duties to challenge and question our self, as we engage in pointing out weaknesses, flaws, mistakes and ethical blindness observed in other colleagues. This action will help us to be productive and awake to the new challenges and possibilities in our profession.

6. Also, as psychologists, we tend to question our ability in areas where we are unclear, while, we find it harder to query our self about what we are more certain of or beyond questioning. It will be more productive and beneficial for us as professionals to ask questions about what we know and follow it to the conclusion. While this might take us to a new challenge, it will also make people around us to see our action as "psychologically improper" (Pope et al., 2006).

7. As psychologists, we frequently bump into ethical problems devoured of clear and easy answers. This mostly happens in boundary issues than any other matter. We might be threatened with vast needs that are unsurpassed by adequate resources, conflicting duties that appear difficult to resolve, and other uncountable problems that we face in our day to day actions as clinicians who offer support for those who are desperate and in need of care. Also, we make unnervingly difficult decisions about boundaries "on the spot" due to clients and colleague's unforeseen statement or actions. As a result, we cannot run away from ethical challenges, as they are part of our professional call.

8. Last but not the least, as psychologists, consultation is crucial and paramount in our day-to-day dealing with clients. We sometimes cover our own personal issues. So, turning to other trusted colleagues, particularly those who are not involved in our situation helps in building our ethical decision-making. Similarly, valuable ideas that are not well-thought-out, particularly unknown biases can be pointed out by colleagues. Furthermore, as we take hard decisions under pressure, we may inadvertently but reasonably become more worried about how the action might affect our duties. For instance, as professionals, we tend to contemplate whether our action can cause us a misconduct suit or accrediting complaint, or estrange us with our dependable referral sources. We also think that our action can cause us to lose our clients or client's provider. Therefore, engaging in consultation helps us to reflect on our decision's outcomes consequences for those who are affected.

## **A decision-making model**

For us as psychologists to continue to emphasize the significant implication of dual relationship and boundary crossing in clinical practice, a variety of ethical issues must be considered if professional standard is to be maintained. Simon and Shuman (2007) in their contribution to ethical decision making, found that a psychologist should always form the habit of upholding applicable boundaries even in the face of working with tough clients and boundary-testing. They argued that in a therapeutic practice, there are neither faultless therapists nor perfect treatment. This statement alone ought to inspire psychologists to be acquainted with their boundaries. It also makes their work easier. This paper used a decision making model to analyze potential dual relationships and the boundary issue in clinical psychology. The model has three advantages that make it appropriate for analysing ethical issues in clinical practice. Firstly, it is specifically designed to address potential dual relationship and ethical problems confronting professionals in clinical practice. Secondly, the model is too broad, i.e., it provides limited direction for professional and narrow, i.e., explained how clinician should behave. Lastly, the model contains all possible dual relationship issues that might happen, irrespective of the situational context.

## **Assumptions**

The decision making model is purposely designed to help professional colleagues to manage their relationships effectively and efficiently, if they realised that they cannot avoid it. The model uses seven assumptions to analyse relationship and boundaries in clinical psychology. As a model that focuses on ethical decision making, it embraces all professional relationships that we undertake in clinical practice. The model is not only limited to interactions with service users, learners, or supervises, it also applicable to anyone who uses psychological services, irrespective of the kind of support provided. The model believes that as professionals, our social role should be professionally oriented, irrespective of our situation and relationship with clients. The model also assumes that, our aspiration should be on how to avoid any act of dual relationships in all our dealings (APA, 1990). This remains impossible in most situations, as we are all confronted with multifaceted problems and challenges. Similarly, Kieth-Spiegel and Koocher (1985) and Haas and Malouf (1989) supported this assertion by reporting that such interactions are not totally avoidable. This supposition is also related to the APA Ethical Principles (APA, 1992) and the concept of overlapping interactions presented by the Feminist Therapy Institute's Code of Ethics (1987).

**Table 1.**Dimensions for ethical decision-making.

<b>Low power</b>	<b>Mid-range power</b>	<b>High power</b>
Little or no personal relationship or persons consider each other peers (may include elements of influence).	Clear power differential present, but the relationship is circumscribed.	Clear power differential with profound personal influence.
<b>Brief Duration</b>	<b>Intermediate Duration</b>	<b>Long Duration</b>
Single or few contacts over short period of time.	Regular contact over a limited period of time.	Continuous or episodic contact over a long period of time.
<b>Specific Termination</b>	<b>Uncertain Termination</b>	<b>Indefinite Termination</b>
Relationship is limited by time externally imposed or by prior agreement of parties who are unlikely to see each other again.	Professional function is completed but further contact is not ruled out.	No agreement regarding when or if termination is to take place.

Thirdly the model assumes that, because of the high inherent risk that clinical psychologists experience daily with clients, any interactions with service users must be assessed critically in order to evaluate possible harm. The model assumes that all dual relationships are oppressive and that engaging in dual relationships come with little or no risk and sometime helpful. However, the act must always be circumvented, if we realise it can lead to harm. Fifthly, the model also educates professionals on how to manage pertinent issues, and make recommendations for action. The model assumes that professional's problem arises when psychologists anticipate adding additional relationship to the current one. However, the model is not planned for lesser relationships. Lastly, the model proposes that in clinical practice, the dimension of any relationship must be measured from the point of view of the service user, and, not that of professionals. While we do not have access to the client's feelings in most circumstances, our decisions must be conservatively done in order to ensure that clients' welfare are protected.

### The model

The decision model is based on three dimensions (Gottlieb, 1986). These dimensions are vital to the ethical decision-making process in clinical practice. The first dimension observed in this paper is power. This is explained as the amount of power that psychologists wield in their relationship with their clients. Although this is widely varied, psychologists who give a talk during community practice have relatively little control over those in the gathering, compared to those that work with clients over a long-term period. Secondly, the time of the relationship, coupled with the aspect of power is relevant in decision making. That is in therapist-client relationship, power rises over time. This means that, the intensity of

power is limited in a brief relationship, such as a single assessment session for referral, and increases as the interactions progress, i.e., student and teacher. Thirdly, the clarity of termination means that the client and the clinician might engage in a further professional contact. For instance, a psychological assessment with a job seeker involves clear-cut termination, with little or no additional contact. Conversely, a clinical psychologist working with family, sometime believes he has a long-term obligation to his client. The question is, how can we terminate a professional relation in clinical practice? This model indicates that, a professional relationship with clients continues until the client thinks otherwise, irrespective of the time or contact in the interim. As soon as the psychologist realises he/she does not understand how the client feels, the ethical choice is to accept that the client has the right to recommence the professional connection in the future (Table 1).

### Application of decision-making model

Decision making model can be applied in clinical practice, particularly, when a psychologist is considering having an additional relationship. This can be achieved through the following process:

Firstly, psychologists need to appraise their present relationship with clients by using the following dimensions: from the client's angle, where do the relationship lies on each? How pronounced is the power difference, for how long is the relationship, and is it evidently over? If the relationship takes the right side on two or three of the scopes (i.e., upper power, lengthier period and no end), the probability of danger is higher; therefore, the clinician must avoid creating any other relationship apart from the existing one. However, for family, group or individual therapist, the circumstances are clear. For them, the



power differential is boundless. This means that the therapy session can be extensive; therefore, ending such session is not explicit. Besides, the clients might believe it is their right to come back for treatment any time they want in the future. Also, some families may perceive a psychologist the way they see a family physician by thinking that he/she will always be accessible anytime they need a service. In such circumstances, the general belief that a professional-client relationship does not end is correct. On the other hand, if the relationship lies on the left flank of the three dimensions (i.e., less power, fewer periods, and clearly ended), one can shift or move down to the subsequent level. But, in a situation where a relationship lies in the middle of the three dimensions, some kinds of extra relationships are allowed, so, the psychologist can possibly move down to the subsequent level.

Secondly, psychologists must observe the anticipated relationship based on the three dimensions analysed in the present interaction with clients. If the expected relationship cascades to the right side of the scopes (i.e., leading to long and indeterminate end), then such relationship must not be jettisoned, particularly, in a situation where the present relationship also cascades to the right. On the other hand, if the projected relationship falls in between the middle and the left side of the scopes, the rapport can be allowed and the psychologist can proceed to step three. For instance, a psychologist might ponder about going into a relationship with a family 'client she has worked with before that needs no further engagement. In this situation, the clinician has enormous power that is short-lived and last for a definite period, and thus makes closing the professional rapport more explicit. The new rapport, though, having unstated and unclear length and termination, comprises little or no power difference. In contrast, if the first relationship falls to the left part of the dimensions, and the anticipated relationship falls to the right side, the relationship can be promoted and allowed, i.e., a psychologist could ponder about assessing a child that he or she has previously engaged with the parents.

Thirdly, psychologists must look at the relationship for any role incongruity and see if they fall in-between the middle or the left side of the dimensions. According to Kitchener (1988), role incongruity rises as a result of the following factors: higher differences in anticipations of the two roles, greater divergence of the duties of the two roles, and last but not the least an upsurge in the power disparity. Whenever the two diverse roles look highly unsuited, the clinician should endeavour to reject or abandon the expected relationship. For instance, a clinician must not take member of staff as a transitory psychotherapy client. But, if the relationship falls in the middle, or left side of the sizes, and the level of unsuitability is small, the clinician can continue with the

relationship. For example, a psychologist might consider one of his employees as a participant in an assessment process he or she is supervising. A psychologist, who worked with a drug addicted man before, might consider working again with him and his spouse for conjugal problems.

Fourthly, clinical psychologists must be ready to engage other professional colleagues in consultation. In line with the seventh assumption, the new relationship must be measured from clients' viewpoint, and judgements must be done in a conservative manner. Meeting with a professional colleague must be seen as normal, when making judgements. A colleague who is used to such situations, i.e., the service user, and the decision-maker is the perfect choice for professional consultation. For instance, an associate might view it ill-advised that a recently divorced, troubled, male medical training supervisor agrees for a date from one of his female interns.

Lastly, it is also imperative for psychologist to always engage clients in decision making, if he or she decided to continue with the extra relationship. The psychologist must assess the following factors, such as the importance of the decision-making model, its justification, the relevant ethical questions, obtainable options, and lastly, likely adverse implications as an element of informed consent. If the client is capable, and decides to involve in an additional relationship, the clinician can continue, once the service user is given ample time to think about the other options. If the service user/client fails to be aware of the quandary or is reluctant to ruminate on the matters before making a choice, he or she is seen as at risk, and the anticipated relationship should be forbidden.

## **METHODOLOGY**

This paper analysed and reviewed empirical literature in order to investigate and check new empirical studies that highlight the complexities of dual relationship and boundary crossing in clinical psychology. The study collated and reviewed relevant articles, books, journals, and meta-analysis on dual relationship, boundary crossing and ethical decision making. Both the ERIC and PSYCHLIT databases were searched using the following key words: ethical decision making, boundary crossing, dual relationship and clinical psychology. This procedure initially reported about 1298 articles, journals, technical reports, paper presentation and book chapters covering more than 23 year period. Based on the abstracts retrieved from this initial 1298 plus articles and publications, the search was lessened to a relatively few hundred of studies that are pertinent and relevant to the theme of this paper. The contents of the remaining several hundred of articles cum journals were further scrutinised and only those that reported empirical findings were kept aside and used in this review, while others were left out for further consideration. This process shows that only a few studies documented empirical findings on boundary crossing and dual relationship in clinical psychology practice. To verify references, manual searches of relevant journals and articles related to the paper are performed.

### Case Study 1

Dr Badmus is a clinical psychologist working in a private psychotherapy clinic. A young lady in her middle twenty was referred to her for relationship issues. After working with her for 3 months, the client thinks that her problems are over and after discussing with the psychologist, they both agreed to end the therapy. Three years later the client and the psychologist, coincidentally, met again at a get together party. They both had a lengthy discussion and at the end of the day, they exchanged address and the client asked the psychologist if they can meet again. The clinician responded and quickly pointed out that he would have loved to take her out, but due to their past professional contact, he would not be able to do so. To buttress his point, he told her that such relationship would affect any future professional consultation she might need from him. She agreed with him, and suggested that if there is any need for future consultation, she would not mind him referring her to a professional colleague. Though they went out together for quite some time, the relationship did not last long. Two years after ending their social relationship, she called the psychologist and requested for service. The clinician declined the consultation by mentioning their last discussion at the party and offered to refer her to a professional colleague. She immediately gets annoyed with the suggestion and bangs the phone. Since then, there has been no contact between them.

### Case analysis

Many people would contend that Dr. Badmus took a good decision the way he handled the situation. He was conscious of the danger that may follow his friendship with a former client. Besides, he was even aware of the informed consent processes in the hub of a social event. But, if all his action is right, then, what is the problem? By using the model to analysis the scenario, it shows that Dr. Badmus had a rapport with high power of intermediate period and a seemingly exact termination. The model also discloses the effect of great role unsuitability when counsellors get involved in a social relationship with former clients. Moreover, Dr. Badmus should have considered the client's need in these circumstances. Though agreed with her, the clinician failed to observe and analyse the intended relationship from the client's perspective. Additionally, the model recommends a waiting period and discussion with a professional colleague. Supposing Dr. Badmus, followed the principle of the model to the end; he might have re-evaluated the situation.

### Case Study 2

Dr. Titus is a private clinical psychologist practitioner; one day he was having a psychotherapy session with a young lady who was having a relationship problem. During the therapy session, the young lady told the clinician about her problem in keeping a long term relationship with the opposite sex. She told the psychologist that since the death of her husband, she has not been able to hold a relationship for a long period. Some weeks later the client called Dr. Titus and reminded him of their conversation and asked if he can recommend somebody for her. As a result of their conversation, Dr Titus decided to consult a trusted professional colleague for advice. After his consultation with a professional colleague, Dr Titus called the client and declined further consultation with her.

### Analysis

In analysing this scenario, some might think Dr. Titus action is

conservative. The client is a mature lady who has a right to make a decision. The model demonstrates that the power differential was in the middle, of unknown closure and perhaps of long period. Dr. Titus recognized that as long as the power differential is sustained, the inharmoniousness in the role would continue. The discussion had shown additional information critical to his decision. Dr Titus understood that if he went ahead and introduce someone to the client and they start a relationship, she might feel indebted to him and susceptible to potential manipulation. Had the relationship failed, the client might displace or have hostile feelings towards him, and this may have an impact on their future professional conduct together. Moreover, Dr Titus followed the model recommendation for a waiting period and discussion with a professional colleague and this went a long way to help him make a positive decision, which was eventually useful in his decision making.

## DISCUSSION AND CONCLUSION

Though the American Psychological Association (APA) came out with elaborate ethical values and principles that guide the professional conduct of its members, there is still lack of comprehensive, systematically gathered data about the degree to which members believe in or comply with these guidelines. Research has long identified lack of broad and scientifically generated data on psychologists' beliefs and compliance with ethical principles as the bane of the profession. As important as they are, such information, as important are not available to guide individual clinical psychologists in their decision making or the APA in their efforts to review, improve, and spread the code of practice. For instance, evidence till date, still shows that little is known about the valuable experience needed in regulating appropriate conduct in clinical practice. As mentioned in most of the ethical literature, the practicability of boundary issues remains unsolved in clinical practice. Although the ethical principle offers common guidelines for clinical psychologist, little or no guideline is offered when it comes to decision making. Nonetheless, there are a number of reasons why ethical conducts continue to influence decision making process in clinical practice. This paper describes the relevant steps that psychologists must follow in the course of making a professional decision, and defines a decision-making model that helps psychologists make professional judgement. Though the model is relevant to psychologists, there are still some issues that need to be solved if professionalism is to be sustained.

Also, the study demonstrated that power differential remained even when it is evidently clear that a service has ended. For instance, some clients strongly believe that they can come back for further service despite the fact that the session has ended. The question is, should we engage former psychotherapy clients in social relationship even with clear evidence to show that the service has ended? If this arises, does making relationship with such client untenable and unwise? This

question continues to influence decision making in clinical practice, thus hampers the success of the therapy. Also psychologists face similar nettlesome conditions when they had middle to long-term personal contact with clients and interns. For instance, in the beginning of the treatment, the power differential was pronounced, and contacts may go on for ages, and then developed into peer, friendly, companion-able or passionate ones. In this case, it is advisable that psychologists take into consideration the issue illustrated earlier, that state that the scopes of the relationship must be viewed from the client's perspectives. So, it is not sufficient to conclude that the approved professional rapport is reaching termination. Finally, as good as a decision making model is to clinical practice, it still lacked empirical validation. Hence, for it to be properly applied in clinical practice, it requires a subtle professional judgement as well as careful and thorough reflection from a clinical psychologist. Finally, it is worth mentioning that consultation is an important ingredient in the decision-making process. There is still no alternative to professional consultation of trusted colleagues.

## **RECOMMENDATION**

As the decisions whether or not to cross a borderline threaten us every day, they are often subtle and influence the progress recorded in the therapy. Although dual relationships sometimes enhance therapy, aid the treatment strategy, and promote the clinician-client working relationship, they also weaken the treatment process, hamper the clinician-client cooperation, and bring instant or lasting damage to the service user. At the individual level, psychologists should take cognisance of their individual and professional needs and be self-care. They should endeavour to achieve those needs without allowing them having any bearing on their relationships with clients. Based on these analyses, this paper recommends that: 1) professionals should position themselves and make sound choices by coming up with a strategy on boundary crossings that focus on their general attitude to ethics. 2) Efforts must be directed toward staying up-to-date with the evolving law, ethical values, research, concept, and practice procedures. 3) Before taking any decision, a psychologist must take into consideration the situational context of each client. 4) Clinical psychologist must involve incritical thinking devoid of common cognitive blunders that can affect clinical duties. 5) Efforts should be directed toward avoiding personal responsibility for our decisions and we should justify our choices and conduct. When we realise our mistake or notice that our boundary choices have led to woe, we should apply accessible means to come up with the best solution to solve the problem.



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