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Ethical Concerns About Dual Relationships in Small and Rural Communities: A Review

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abstract

Dual relationships between therapists and clients (i.e., any relationships beyond the strictly professional), are generally considered inappropriate in the mental health professions. However, within the context of small and rural communities they are an almost inevitable part of every-day practice. The aim of this literature review is to provide an introduction to the ethics of dual relationships by focusing on the risks and opportunities that arise within complex relationships. Furthermore, it offers guidelines on how to determine the potential for harm in non-professional relationships with a client. It concludes by noting that dual relationships are ethically more complex than they may first appear.

Keywords*:* dual relationship, rural practice, ethics, psychotherapy

On a daily basis, mental health professionals and their clients interact in various therapy settings. Within this close context, interactions are based on a therapeutic alliance with the purpose of helping clients with their difficulties. Establishing this primary relationship is an important central feature for the majority of therapeutic approaches and thus desirable. Nevertheless, different forms of relating might co-emerge over the course of treatment, or shortly after termination. For example, what if both client and therapist share a church, meet regularly at the grocery store, or have a mutual friend? These non-primary relationships certainly pose several ethical concerns and challenges for every-day practice such as ensuring confidentiality, or maintaining a professional distance.

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Defining Dual Relationships

Whenever a mental health professional or client initiates a relationship other than the one preconditioned by the therapy setting, they enter the domain of dual relationships (Gross, 2005a; Moleski & Kiselica, 2005). It is important to point out that this initiation could happen during, after, or even prior to therapy (Gross, 2005a). Historically, dual, or even multiple relationships are considered to have a negative connotation, and are often associated with client-exploitation and sexual transgressions (Cottone, 2005; Gross, 2005b). Nevertheless, definitions of relationships outside the necessary therapeutic alliance are rather broad. They often address non-professional relationships, such as

sharing a congregation or having children at the same school (Cottone, 2005; Moleski & Kiselica, 2005). Other definitions involve less obvious relationships that are embedded within a therapist's different professional roles. For example, at any point time a therapist is a helper, a note-taker who will keep track of sessions, and a source of information for health care systems (Cottone, 2005; Moleski & Kiselica, 2005). This second type of complex relationship has its own pitfalls, especially in times of managed care and lawsuits (Gross, 2005a; Cottone, 2005). However, emphasis is usually placed on non-professional dual relationships which form the main focus of this review.

Dual Relationships are More Frequent in Some Contexts

The general approach towards dual relationships, as reflected by the ethical codes and standards of mental health professionals' associations, has been one of minimization (Brownlee, 1996; Cottone, 2005; Gross, 2005a; Stockman, 1990). However, there are several sets of circumstances that make it nearly impossible to completely bypass dual relationships. In small and rural communities this is a particular issue since social overlap is difficult to avoid. In rural settings, a mental health professional, while being part of the local community, will most likely be the only available option for treatment (Stockman, 1990).

Other situations that may generate dual relationships are those of matched minorities. For example, deaf clients will have substantially reduced options of finding a therapist able to provide sessions in sign language. At the same time, the chances that such a therapist will be part of a deaf community are high even in major urban environments. The same conditions apply to various ethnic, linguistic, and other minorities. For example, a client from a specific ethnic or cultural background (e.g., Hmong, an Asian ethnic group that migrated to the US in large numbers after the Vietnam War) might be more comfortable seeking help from someone of their own ethnic or cultural group. For example, a client could find it easier to relate to a professional who has the same cultural background and speaks their native language. However, ethnic and cultural diversity among mental health professionals is limited (Bui & Takeuchi, 1992), which raises a different set of challenges that will not be addressed here.

Ethical Drawbacks and Benefits of Dual Relationships

As mentioned previously, many (mental) health associations address dual relationships in their ethic codes or guidelines, which are readily available through their websites (American Psychological Association, 2010; British Psychological Society, 2009; Canadian Psychological Association, 2000). This is likely due to the fact that about half of the complaints and lawsuits filed against therapists address some of the concerns related to dual relationships (Gross, 2005a). The main concern is that dual relationships could cause harm to a client (Cottone, 2005; Moleski & Kiselica, 2005). This concern seems to be legitimate given the high percentage of complaints related to this matter. There are two main ways in which engaging in dual relationships can harm a client. First, it can cause a loss of professionalism by a therapist that could result in poor judgment and decision making Brownlee, 1996). Second, harm is usually connected to some kind of exploitation of the client, be this an undue exertion of power, or even sexual transgression (Gross 2005b; Kitchener 1988). The latter is clearly addressed and forbidden in the ethical codes of mental health associations (Cottone, 2005; Gross 2005b; Syme, 2006), as well as by law. Engaging in any kind of sexual behavior, from verbal and physical insinuations to actual sexual relations, is considered unethical with current clients and highly problematic with former clients (Moleski & Kiselica, 2005). The notion that sexual

relations with a therapist will harm a client is backed up by research and generally undisputed (Gross 2005b).

The position on non-sexual relationships is not as clear. While it would be easy and unambiguous to place a general ban on all dual relationships (Kagle & Giebelhausen, 1994), in practice this would neither be practical, nor desirable (Brownlee, 1996; Stockman, 1990). Even in big urban environments, therapists and clients can potentially meet in a non-therapeutic setting by accident (Gross, 2005a). The common practice of private and word-of-mouth referral may also result in having to deal with two clients that are good friends, a situation that constitutes a type of dual relationship (Gross, 2005b). Being referred to a specific therapist by a close friend can, in turn, help establish trust and a working alliance. In fact, when they are appropriately monitored, dual relationships can not only have therapeutic value (Gross, 2005b), but avoiding them altogether can actually have detrimental effects on a client (Moleski & Kiselica, 2005; Stockman, 1990). Specifically, refusing to go to a personal event or avoiding all contact with clients outside of therapy can result in a breach of trust and disrupt the treatment, thus causing harm to clients (Stockman, 1990). For example, a client may justifiably feel that therapy has had an immense impact on their private life and subsequently invite their therapist to attend their wedding. If the therapist did not attend the wedding, this might cause the client to think that the therapist's interest in their life may be disingenuous, potentially creating a setback to the therapeutic relationship. Consequently, managing the potential blurriness of dual relationships should be a primary focus for mental health professionals.

The blurring of clear therapist/client roles can lead to anything from mild discomfort to high distress in a client (Gross, 2005b), and should thus always be addressed and clarified in therapy. This would appear a more tenable approach than an indiscriminate ban on all kinds of dual relationships. However, there is a clear need to resolve the ambiguities in ethical codes and to determine ways in which to deal with dual relationships when they seem unavoidable (Brownlee, 1996; Kitchener 1988). Some of the ethical principles arising on the therapist's side of a dual relationship are those of justice (e.g., do they attend every client's private events, or just some?), confidentiality (e.g., do they greet clients in the grocery store and risk the client's exposure?), and autonomy (e.g., should a client's wish for an out-of-therapy interaction be granted?). In any case, a therapist has the responsibility to make an informed decision and to balance these types of concerns with those of potential harm to ensure a client's overall progress.

Dual Relationships in Small and Rural Communities

While some of the above examples of dual relationships may occur in any urban setting, small and rural communities often generate many complex relationships. It is more common than not to occupy several roles at the same time (Brownlee, 1996). A hypothetical but realistic example is that of a local mental health professional, who as a parent may be part of a small community's school-board while at the same time be treating a teacher of that school, who is, or may become their child's homeroom teacher. Since this is less likely to happen in an urban setting with more than one school and a number of mental health resources, a different set of ethical guidelines may apply in less densely populated areas. Research offers compelling evidence that rural practice is qualitatively different from urban practice when it comes to the ethics of dual relationships (Helbok, Marinelli, & Walls, 2006). Stockman (1990) argued that by isolating themselves from the local community mental health professionals would likely dissuade people seeking help. Therefore, therapists need strategies to effectively address and evaluate how their multiple relationships with clients may affect treatment.

Kitchener (1988) proposed a threefold model that focused on role expectations and the conflicts that may

result from such expectations. First, the level of potential harm could mainly be determined by the grade of incompatibility of the expectations that both the therapist and client have towards the different roles they hold. Consequently, the more expectations diverge, the more the dual relationship would lead to harm (Kitchener, 1988). One of the roles occupied by a therapist is that of a 'friendly listener'. Returning to the previous example of the client-teacher, being a friendly listener could lead to expectations of friendship-based behavior, such as joining forces in the school-board, or downplaying mental struggles in a professional evaluation of the teacher's ability to work. If the therapist did not comply with such expectations, relational discord would be more likely to occur. To specify Kitchener's proposition, the more a client sees their therapist as a friend, the more detrimental it is likely to be when their therapist dismisses a client's expectations of social affiliation.

In a second step, the issue of plural obligations was addressed. In the example above, the mental health professional is part of the school board and treating a teacher of the same school. Thus, a conflict may occur in which the role obligations of those positions may collide. For example, the question of whether the teacher is able to teach in spite of obvious personal struggle could place the therapist in a compromising position regarding confidentiality. Moreover, if this situation also involved a possibility of the teacher being suspended from work, the therapist would need to balance their client's needs with those of the school and their own child's education. More specifically, having a job could be an essential component of the client's self-esteem and losing their job, even if temporarily, it could be detrimental. Conversely, the teacher may not be emotionally stable and reliable enough to be trusted with a class. A scenario such as this highlights the complexity of dual relationships and can place a therapist in a very complicated position.

The third risk-factor included in the model is that of a power imbalance which may arise within a dual relationship. According to Kitchener (1988), whenever the power balance is disturbed by shifting focus toward the therapist, the risk of exploitation is substantially increased. Having to fulfill several roles at the same time, the danger of incompatibility becomes heightened in the face of uneven power distribution (Kitchener, 1988). Thus, it would be ill-advised for a therapist to treat their own housekeeper since the power hierarchy of their relationship could have an impact on developing a therapeutic one. Following Kitchener's model, it is mandatory to prioritize the needs of the client over those of the therapist at all times. To act in accordance with this principle may be difficult, particularly when the therapist's needs or goals overlap with parts of the larger community as in the school related example above. However, it is important to emphasize that this guideline can be used to asses both the negative and positive potential of dual relationships. When any of the three domains are out of balance or conflicted, a dual relationship bears a higher potential of having a negative impact. Conversely, when the domains are balanced and healthy, it becomes increasingly likely that this particular dual relationship may be an asset to a client's treatment.

While this kind of theoretical model seems relevant to rural practice, it does not seem to be widely applied. Indeed, the most important concern pointed out by most therapists in a survey conducted by Helbok et al. (2006), was to openly address possible issues related to dual relationships. Why existing models and theories are rarely applied in practice, may be explained by a general lack of training in the area of dual relationships (Halverson & Brownlee, 2010; Helbok et al., 2006). Responsibility for this may in part be due to the urban focus of current therapist training (Helbok et al., 2006; Schank & Skovholt, 1997). Thus, most therapists are forced to resort to intuition and experience rather than evidence based practice guidelines to address this issue (Halverson & Brownlee, 2010).

Most of these intuitive techniques seem to be based on assessing two crucial states: the level of intimacy and/or quality of the dual relationship and the type and severity

of the client's problem (Halverson & Brownlee, 2010; Schank & Skovholt, 1997). When already engaged in a dual relationship, many therapists will readily agree to see clients with clear-cut and less severe symptoms while being more cautious when it comes to grave personality disorders (Schank & Skovholt, 1997). This may be based on a belief that clients with severe personality or delusional disorders may be less able or inclined to respect boundaries set by the therapist.

In the matter of intimacy the position is less clear. Some therapists feel that strong and multiple ties to a client are highly beneficial (Halverson & Brownlee, 2010). Meanwhile, others see the need to reduce dual relationships to a minimum (Schank & Skovholt, 1997). Both positions have value since what matters is how in control and comfortable the involved parties feel. As long as a client's autonomy is not endangered, a therapist would be likely to feel able to maintain objectivity, and comply with set boundaries (Halverson & Brownlee, 2010; Kitchener, 1988). In any case, there appears to be concensus among therapists on the need to properly address the implications of dual relationships early on (Brownlee, 1996; Gross, 2005b), in addition to constant documentation and assessment of non-professional relationships outside of a therapy setting (Gross, 2005b; Schank & Skovholt, 1997).

Implications for Therapists Practicing in Rural/Small Communities

The main concern surrounding dual relationships is centered on the possible harm to a client. Nevertheless, practicing within closely knit and/or geographically confined communities can also inflict strains upon mental health professionals. In a survey conducted by Helbok et al. (2006), an issue that clearly distinguished rural from urban practitioners was a feeling of being at work 24 hours a day. The heightened visibility of the therapist, as well as constant encounters with current or former clients, could very likely be responsible for this feeling. Another factor that places additional pressure on rural practitioners is the involvement of their own family with current or former clients. In their study, Schank and Skovholt (1997) provided testimony by psychotherapists who had to decide on whether to limit their personal or families' social life, or allow indiscriminate contact with current or former clients. One of the reported examples was that of a therapist whose daughter dated several boys that were or had been clients. Several problems arose from this situation. First, due to confidentiality, the therapist could not disclose her professional relationship with the boys to her daughter leading to conflict once the boys informed the therapist's daughter. Second, the therapist's unique level of personal information on the boy(s) may have influenced the approval of a possible relationship with their daughter, again touching on issues of confidentiality. Another example was one therapist's lack of ability to bargain with his client and mechanic and canceling a YMCA membership due to awkward encounters with clients (Schank & Skovholt, 1997).

Despite all these additional stressors, rural practitioners do not seem to have elevated rates of burnout (Helbok et al., 2006). This finding points towards the relative effectiveness of the strategies used by mental health professionals working under these specific circumstances. Being able to successfully maintain the therapist or client role appears essential to the success of whatever strategies are in place. Indeed, Schank and Skovholt (1997) have reported that having out-of-session contact with a client is not inherently bad as long as both parties are able to distinguish between their professional and social relationships. Still, current training is very unlikely to emphasize these skills due to the relatively small number of dual relationships which occur in highly populated areas.

Related to the need for separation of social and professional lives is a concern that can arise from the high visibility of the therapist's private life in rural communities. Sharing many private situations with clients

can result in an increased pressure for the therapist to appear flawless. Helbok et al. (2006) gave an example of a therapist being anxious about her children misbehaving in church. The anxiety provoked by this kind of situation may stem from a fear of losing respect from their clients, as clients may be taken aback by seeing their mental health provider struggling with everyday issues. However, as Schank and Skovholt (1997) have suggested, heightened contact with the community can also be embraced and used for effective role-modeling, although engaging in this kind of activity could undermine a therapist's authenticity if used too often. Observing first hand that the health provider is also 'just' a fallible person can be helpful to establish trust. . It may even serve a therapeutic function as a client can see how their therapist also works through their difficulties in a variety of settings.

This ubiquitous interrelatedness of professional and private spheres in small and rural communities is more acceptable for some therapeutic approaches than for others (for basic concepts and processes of different therapeutic schools, see Corsini & Wedding, 2011). A clear example is the need for neutrality in psychodynamic therapy. A practitioner that works within a humanistic or behavioral approach will have less trouble adjusting to the particular challenges of practicing and living in a small community than his psychodynamically oriented colleague since the former is allowed a higher degree of personal disclosure than the latter. This may then limit the range of therapy available to clients in rural settings, as specific types of therapy will be selected with consideration of environmental factors.

Another interesting finding has been that health professionals in rural settings breached client confidentiality less than their urban based counterparts (Helbok et al., 2006). This finding may seem counter-intuitive as confidentiality is more difficult to preserve in a small community than in the more anonymous context of an urban centre. However, closer examination suggests that urban practitioners are more likely to share case-information with colleagues, friends and family, as they can withhold the name of the client to preserve their confidentiality. Conversely, practitioners in rural settings face the possibility that others may deduce who a client is from case-information, requiring restraint from sharing anything with others at all (Helbok et al., 2006). Arguably, this lack of ability to talk with others, due to fear of unintentional breaching of confidentiality, and a lack of colleagues, may cause notable pressure on an individual therapist.

Conclusion

The matter of dual relationships is highly important, as engaging in them can potentially cause harm to clients. While sexual relationships are banned in all ethical and practice guidelines, the boundaries surrounding non-sexual dual relationships are less clear, especially in the context of small and rural communities. Mental health practitioners who live and work in a rural setting are often on their own and thus do not have the possibility to re-refer their clients to a colleague when a dual relationship emerges. . These challenges force them to deal with the ethical issues surrounding dual relationships rather than being able to avoid them. Consistently, research has reported much higher rates of engaging in dual relationships for mental health professionals working in close-knit communities. Out of this interchange between private and professional settings arises a need for clear boundaries and strategies to appropriately address these situations and avoid harm. However, current therapist training is influenced by urban environments, thus not providing guidelines needed for practitioners in rural communities. It would seem important to develop therapist training curricula by incorporating specialized courses concerning dual relationships, and the ethics surrounding them. This becomes even more important for those going into rural communities since the need and frequency of engaging in dual relationships may lead to decreased concern and alertness to potential risks. While

there is some evidence in support of developing dual relationships, they should not be taken lightly and need to be closely monitored and analyzed in order to prevent harm to a client. Overall, there is a need to further look at how future professionals are trained to appropriately address complex ethical situations such as dual relationships. The available data provides a strong basis for future research directed towards developing functional tools for mental health professionals. Having a set of tools (e.g., manuals, guidelines, etc.) could pose a valuable support for practitioners in small communities, giving them a clear way to navigate the complex issues surrounding their relationships with clients. The benefits of research in this area also extend to clients, as the potential for harm arising from inappropriately managed dual relationships could be reduced.

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