Third Edition

Boundary Issues in Counseling

Multiple Roles and Responsibilities

Barbara Herlihy
Gerald Corey

American Counseling Association

WILEY

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American Counseling Association
5999 Stevenson Avenue • Alexandria, VA 22304
www.counseling.org

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10 9 8 7 6 5 4 3 2 1

American Counseling Association
5999 Stevenson Avenue • Alexandria, VA 22304

Associate Publisher Carolyn C. Baker

Production Manager Bonny E. Gaston

Copy Editor Kay Mikel

Editorial Assistant Catherine A. Brumley

Cover and text design by Bonny E. Gaston.

Library of Congress Cataloging-in-Publication Data

Herlihy, Barbara.
Boundary issues in counseling: multiple roles and responsibilities/ Barbara Herlihy and Gerald Corey.—Third Edition.
pages cm
Includes bibliographical references and index.
ISBN 978-1-55620-322-0 (alk. paper)
1. Counseling. 2. Counseling—Moral and ethical aspects. I. Corey, Gerald. II. Title.
[DNLM: 1. Counseling. 2. Ethics, Professional. 3. Professional-Patient Relations.]
BF636.6.H47 2014
174′.91583—dc23 2013048787

To our colleagues who struggle with the issues in this book.

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Preface

Dual or multiple relationships may be among the most controversial of all issues in the counseling profession. They have been the subject of extensive debate that has produced many questions and has moved us toward a stance on multiple relationships that is more flexible and culturally sensitive. We expect that this book will be useful to others who share our interest in boundaries and dual or multiple relationships and who struggle, as we do, to find a clear personal stance on the issues involved.

This book is a resource that reflects the current thinking of our profession on boundary issues, but we also wanted it to represent a diversity of opinion and perspectives. To that end, we have invited 40 guest contributors (30 of whom are new to this edition) to share their thoughts.

New and updated contributions focus on multicultural and social justice perspectives on cultural boundaries and offer insights into counseling Latino, African American, and Muslim clients. Our guest contributors address boundary considerations in a number of new and emerging specialty areas of practice, including disaster mental health work, social media friendships and school counselors, working with clients with end-of-life concerns, managing multiple relationships in military settings, in-home service delivery, and a postmodern perspective on ethical decision making. Other new topics include the client's perspective on the impact of sexual boundary violations; managing sexual attractions; multiple roles that doctoral students are challenged to play; addressing supervisee incompetence; challenges in the supervision of addictions counselors; and school counselor boundaries with teachers, administrators, and parents. This third edition provides a

look at current thinking and discussions on professional boundaries and multiple relationships in our changing world. In addition to the contributed pieces, all the chapters have been revised, most chapters contain expanded discussions on the topics, new trends have been identified, and current literature is cited.

This third edition highlights the revised ethics code of the American Counseling Association (2014) as well as specific standards drawn from the ethics codes of the American Association for Marriage and Family Therapy (2012), American Psychiatric Association (2013b), American Psychological Association (2010), American School Counselor Association (2010), Association for Counselor Education and Supervision (1993), Association for Specialists in Group Work (2008, 2012), Canadian Counselling and Psychotherapy Association (2007), Commission on Rehabilitation Counselor Certification (2010), International Association of Marriage and Family Counselors (2011; Hendricks, Bradley, Southern, Oliver, & Birdsall, 2011), and National Association of Social Workers (2008).

We have organized the book to begin with a general introduction and overview of dual or multiple relationships and a range of boundary issues in counseling practice. We define the issues and areas of concern (Chapter 1), then focus on sexual dual relationships (Chapter 2) and present the client's perspective (Chapter 3). Chapter 4 addresses multicultural and social justice perspectives on boundaries, which is a foundation for many of the chapters that follow. Chapter 5 examines boundary issues in counselor education and is followed by chapters on supervision and consultation (Chapter 6), the education and training of group counselors (Chapter 7), group counseling and couples and family counseling (Chapter 8), and school counseling (Chapter 9). Chapter 10 focuses on the specialty areas of disaster mental health, private practice, addictions counseling, and rehabilitation counseling. In Chapter 11 we focus on unique boundary issues that arise for practitioners in rural practice, counselors in the military, counseling clients with end-of-life concerns, providing in-home service, and counselors working in forensic settings. Chapter 12 reviews 11 key themes in this book, asks questions to encourage integration and reflection, and offers a decision-making model.

We make no claim to having discovered the answers to many complex and difficult questions. Rather, it is our aim to raise issues, present a range of viewpoints, and discuss our own position. Our hope is that you will use this material as a springboard for further reflection and discussion. We invite you to think about the issues that are raised, apply them to your own work, and discuss them with colleagues.

This book focuses on boundary issues with a wide variety of client populations. Although the topic is narrow in focus, dual and multiple relationships are pervasive in the helping professions. This book is a valuable supplement for courses in ethics and professional issues and for practicum, fieldwork, and internship seminars. We hope counselor educators,

clinical supervisors, and students benefit from the personal perspectives provided that identify potential problems and suggest solutions when crossing boundaries in dual or multiple relationships. Our aim is to aid all practitioners who struggle with boundary issues in their work today.

About the Authors

Barbara Herlihy, PhD, LPC, LPC-S, is University Research Professor in the Counselor Education graduate program at the University of New Orleans. She has served on the American Counseling Association (ACA) Ethics Committee as chair (1987–1989) and as a member (1986–1987, 1993–1994) and as a member of the task forces to revise the 1995 and 2005 ACA codes of ethics.

Dr. Herlihy is the coauthor of several books on ethical issues in counseling: *Ethical, Legal, and Professional Issues in Counseling* (with Ted Remley, 2014); *Boundary Issues in Counseling* (1997, 2006), the *ACA Ethical Standards Casebook* (1996, 2006), and *Dual Relationships in Counseling* (1992)—all with Gerald Corey; and the *ACA Ethical Standards Casebook* (with Larry Golden, 1990). She is also the author or coauthor of more than 50 journal articles and 25 book chapters on ethics, multicultural counseling, feminist therapy, and other topics. She is the recipient of the Southern Association for Counselor Education and Supervision Courtland Lee Social Justice Award and the Association for Counselor Education and Supervision Distinguished Mentor Award. She is a frequent presenter of seminars and workshops on ethics across the United States and internationally, most recently in Malta, Venezuela, and Mexico.

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Dr. Corey has authored or coauthored 15 textbooks in counseling that are currently in print, has made five educational DVD programs on various aspects of counseling, and has written numerous articles and book chapters. Some of his coauthored books include *Issues and Ethics in the Helping Professions* (with Marianne Schneider Corey, Cindy Corey, and Patrick Callanan, 2015), *Becoming a Helper* (with Marianne Schneider Corey, 2011), *I Never Knew I Had a Choice* (with Marianne Schneider Corey, 2014), *Groups: Process and Practice* (with Marianne Schneider Corey and Cindy Corey, 2014), and *Theory and Practice of Counseling and Psychotherapy* (2013). In the past 35 years the Coreys have conducted group counseling training workshops for mental health professionals at many universities in the United States as well as in Canada, Mexico, China, Hong Kong, Korea, Germany, Belgium, Scotland, England, and Ireland.

Guest Contributors

Our guest contributors have enriched this book immensely. They have provided a diversity of perspectives, including those of student, counselor educator and supervisor, practitioner, and specialist. They have shared their thoughts and opinions and have raised issues that are well worth considering. These contributors (and the chapters in which their contributions appear) are as follows:

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Chapter 1

Boundary Issues in Perspective

Dual or multiple relationships occur when a professional assumes two or more roles simultaneously or sequentially with a person seeking his or her help. This may involve taking on more than one professional role (such as counselor and teacher) or combining professional and nonprofessional roles (such as counselor and friend or counselor and lover). Another way of stating this is that a helping professional enters into a dual or multiple relationship whenever the professional has another, significantly different relationship with a client, a student, or a supervisee.

Multiple relationship issues exist throughout our profession and affect virtually all counselors, regardless of their work setting or the client populations they serve. Relationship boundary issues have an impact on the work of helping professionals in diverse roles, including counselor educator, supervisor, agency counselor, private practitioner, school counselor, college or university student personnel specialist, rehabilitation counselor, and practitioner in other specialty areas. These issues affect the dyadic relationship between counselor and client, and they can also emerge in complex ways in tripartite relationships (such as client/supervisee/supervisor or client/consultee/consultant) and in family therapy and group work. No professional remains untouched by the potential difficulties inherent in dual or multiple relationships.

This book is a revision of our earlier editions, *Dual Relationships in Counseling* (Herlihy & Corey, 1992) and *Boundary Issues in Counseling: Multiple Roles and Responsibilities* (Herlihy & Corey, 1997, 2006b), but with an expanded focus. Since we last wrote together about this topic, helping professionals have continued to debate issues of multiple relationships, roles, and responsibilities; power; and boundaries in counseling.

Because of the complexities involved, the term *multiple relationship* is often more descriptive than *dual relationship*. *Dual* or *multiple relationships* occur when mental health practitioners interact with clients in more than one relationship, whether professional, social, or business. In the most recent versions of the *ACA Code of Ethics* (American Counseling Association [ACA], 2005, 2014), both of these terms have been replaced with the term *nonprofessional interactions* to indicate those additional relationships other than sexual or romantic ones. In this book, we continue to use the terms *dual* or *multiple relationships* to describe these nonprofessional relationships as well as dual professional relationships.

This revised edition is based on the assumption that counseling professionals must learn how to *manage* multiple roles and responsibilities (or nonprofessional interactions or relationships) effectively rather than learn how to *avoid* them. This entails managing the power differential inherent in counseling or training relationships, balancing boundary issues, addressing nonprofessional relationships, and striving to avoid using power in ways that might cause harm to clients, students, or supervisees. This book rests on the premise that we can develop ethical decision-making skills that will enable us to weigh the pros and cons of multiple roles and nonprofessional interactions or relationships.

Beginning in the 1980s, the counseling profession became increasingly concerned with the ethical issues inherent in entering into multiple relationships and establishing appropriate boundaries. Much has been written since then about the harm that results when counseling professionals enter into sexual relationships with their clients. Throughout the 1980s, sexual misconduct received a great deal of attention in the professional literature, and the dangers of sexual relationships between counselor and client, professor and student, and supervisor and supervisee have been well documented. Today there is clear and unanimous agreement that sexual relationships with clients, students, and supervisees are unethical, and prohibitions against them have been translated into ethics codes and law. Even those who have argued most forcefully against dual relationship prohibitions (e.g., Lazarus & Zur, 2002; Zur, 2007) agree that sexual dual relationships are *never* acceptable. We examine the issue of sexual dual relationships in detail in Chapter 2.

In the 1990s and until the turn of the century, nonsexual dual and multiple relationships received considerable attention in professional journals and counseling textbooks. The codes of ethics of the ACA (2014), the American School Counselor Association (ASCA; 2010), the American Psychological Association (APA; 2010), the National Association of Social Workers (NASW; 2008), and the American Association for Marriage and Family Therapy (AAMFT; 2012) have all dealt specifically and extensively with topics such as appropriate boundaries, recognizing potential conflicts of interest, and ethical means for dealing with dual or multiple relationships. Since this book was last revised in 2006, new articles on these topics

have slowed to a trickle in the professional literature. There has been an increasing recognition and acceptance that dual or multiple relationships are often complex, which means that few simple and absolute answers can neatly resolve ethical dilemmas that arise. It is not always possible for counselors to play a singular role in their work, nor is this always desirable. From time to time we all will wrestle with how to balance multiple roles in our professional and nonprofessional relationships. Examples of problematic concerns associated with dual relationships include whether to barter with a client for goods or services, whether it is ever acceptable to counsel a friend of a friend or social acquaintance, whether to interact with clients outside the office, how a counselor educator might manage dual roles as educator and therapeutic agent with students, how to ethically conduct experiential groups as part of a group counseling course, and whether it is acceptable to develop social relationships with a former client.

In this chapter, we focus on nonsexual dual relationships that can arise in all settings. One of our guest contributors, Arnold Lazarus, makes a case for the potential benefits of transcending boundaries. He takes the position that benefits can accrue when therapists are willing to think and venture outside the proverbial box. The following questions will guide our discussion:

- What guidance do our codes of ethics offer about dual or multiple nonprofessional relationships?
- What makes dual or multiple relationships problematic?
- What factors create the potential for harm?
- What are the risks (and benefits) inherent in dual or multiple relationships, for all parties involved?
- What important but subtle distinctions should be considered?
- What safeguards can be built in to minimize risks?

Ethical Standards

The codes of ethics of all the major associations of mental health professionals address the issue of multiple relationships. To begin our discussion, consider these excerpts from the codes of ethics for mental health counselors, marriage and family therapists, social workers, school counselors, and psychologists.

The *ACA Code of Ethics* (ACA, 2014) provides several guidelines regarding nonprofessional interactions. Counselors are advised that:

> **Sexual and/or Romantic Relationships Prohibited**
> Sexual and/or romantic counselor–client interactions or relationships with current clients, their romantic partners, or their family members are prohibited. This prohibition applies to both in-person and electronic interactions or relationships. (Standard A.5.a.)

> **Previous Relationships**
> Counselors consider the risks and benefits of accepting as clients those with whom they have had a previous relationship. These potential clients may include individuals with whom the counselor has had a casual, distant, or past relationship. Examples include mutual or past membership in a professional association, organization, or community. When counselors accept these clients, they take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs. (Standard A.6.a.)
>
> **Extending Counseling Boundaries**
> Counselors consider the risks and benefits of extending current counseling relationships beyond conventional parameters. Examples include attending a client's formal ceremony (e.g., a wedding/commitment ceremony or graduation), purchasing a service or product provided by a client (excepting unrestricted bartering), and visiting a client's ill family member in the hospital. In extending these boundaries, counselors take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no harm occurs. (Standard A.6.b.)
>
> **Documenting Boundary Extensions**
> If counselors extend boundaries as described in A.6.a. and A.6.b., they must officially document, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. When unintentional harm occurs to the client or former client, or to an individual significantly involved with the client or former client, the counselor must show evidence of an attempt to remedy such harm. (Standard A.6.c.)

The standard of the *AAMFT Code of Ethics* (AAMFT, 2012) dealing with dual relationships advises therapists to avoid such relationships due to the risk of exploitation:

> Marriage and family therapists are aware of their influential position 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. (1.3.)

The NASW (2008) code of ethics, using language similar to that of the AAMFT, focuses on the risk of exploitation or potential harm to clients:

> 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.) (1.06.c.)

The *Ethical Standards for School Counselors* (ASCA, 2010) also advises that school counselors avoid dual relationships that carry a potential risk of harm and, like the ACA, suggests safeguards. The school counselors' code is the only one, among those reviewed here, that addresses the burgeoning usage of social media and its potential for creating inappropriate relationships between students and professionals.

> Professional school counselors:
>
> Avoid dual relationships that might impair their objectivity and increase the risk of harm to the student (e.g., counseling one's family members, close friends or associates). If a dual relationship is unavoidable, the school counselor is responsible for taking action to eliminate or reduce the potential for harm to the student through the use of safeguards, which might include informed consent, consultation, supervision and documentation. (A.4.a.)
>
> Maintain appropriate professional distance with students at all times. (A.4.b.)
> Avoid dual relationships with students through communication mediums such as social networking sites. (A.4.c.)

The APA (2010) code addresses multiple relationships quite extensively:

> (a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.
>
> 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.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.
(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (3.05.)

As can be seen, the ethics codes for mental health professionals all take considerable care to address dual and multiple relationships. Ethical problems often arise when clinicians blend their professional relationships with other kinds of relationships with a client. The ethics codes of most professional organizations currently warn against crossing these boundaries when it is not in the best interests of the client. The emphasis is no longer on an outright prohibition of dual or multiple relationships; rather, the focus has shifted to avoiding the misuse of power and exploitation of the client. Also, it is increasingly acknowledged that some nonprofessional relationships are potentially beneficial.

What Makes Dual or Multiple Relationships So Problematic?

Dual and multiple relationships are fraught with complexities and ambiguities that require counselors to make judgment calls and apply the codes of ethics carefully to specific situations. These relationships are problematic for a number of reasons:

- They can be difficult to recognize.
- They can be very harmful; but they are not always harmful, and some have argued that they can be beneficial.
- They are the subject of conflicting views.
- They are not always avoidable.

Dual or Multiple Relationships Can Be Difficult to Recognize

Dual or multiple relationships can evolve in subtle ways. Some counselors, counselor educators, or supervisors may somewhat innocently establish a form of nonprofessional relationship. They may go on a group outing with clients, students, or supervisees. A counselor may agree to play tennis with a client, go on a hike or a bike ride, or go jogging together when they meet by accident at the jogging trail. Initially, this nonprofessional interaction may seem to enhance the trust needed to establish a good working relationship in therapy. However, if such events continue

to occur, eventually a client may want more nonprofessional interactions with the therapist. The client may want to become close friends with the counselor and feel let down when the counselor declines an invitation to a social event. If a friendship does begin to develop, the client may become cautious about what he or she reveals in counseling for fear of negatively affecting the friendship. At the same time, the counselor may avoid challenging the client out of reluctance to offend someone who has become a friend.

It can be particularly difficult to recognize potential problems when dual relationships are sequential rather than simultaneous. A host of questions present themselves: Can a former client eventually become a friend? How does the relationship between supervisor and supervisee evolve into a collegial relationship after the formal supervision is completed? What kinds of posttherapy relationships are ever acceptable? These questions are explored in later chapters.

Dual or Multiple Relationships Are Not Always Harmful, and They May Be Beneficial

A wide range of outcomes to dual or multiple relationships is possible, from harmful to beneficial. Some dual relationships are clearly exploitive and do serious harm to the client and to the professional involved. Others are benign; that is, no harm is done. In some instances, dual relating may strengthen the therapeutic relationship. Moleski and Kiselica (2005) provide a review of the literature regarding the nature, scope, and complexity of dual relationships ranging from the destructive to the therapeutic. They suggest that counselors who begin a dual relationship are not always destined for disaster. They describe some therapeutic dual relationships that complement and enhance the counseling relationship. For example, in counseling clients from diverse cultures, practitioners may find it necessary to engage in boundary crossings to establish the counseling relationship. Moleski and Kiselica maintain that the positive or negative value of the secondary relationship is determined by the degree to which it enhances the primary counseling relationship. Therapeutic dual relationships are characterized by the counselor's commitment to doing what is in the best interest of the client.

Consider the following two examples. The first is a harmful dual relationship; the second could be described as benign or even therapeutic.

- *A high school counselor enters into a sexual relationship with a 15-year-old student client.*
- All professionals agree that this relationship is exploitive in the extreme. The roles of counselor and lover are never compatible, and the seriousness of the violation is greatly compounded by the fact that the client is a minor.

- *A couple plans to renew their wedding vows and host a reception after the ceremony. The couple invites their counselor, who attends the ceremony, briefly appears at the reception to offer her best wishes to the couple, and leaves. The couple is pleased that the counselor came, especially because they credit the counseling process with helping to strengthen their marriage.*
- Apparently, no harm has been done. In this case the counselor's blending of a nonprofessional role with her professional role could be argued to be benign or even beneficial to the counseling relationship.

Dual and Multiple Relationships Are the Subject of Conflicting Views

The topic of dual and multiple relationships has been hotly debated in the professional literature. A few writers argue for the potential benefits of nonsexual dual relationships, or nonprofessional relationships. Zur (2007) asserts that boundary crossings are not unethical and that they often embody the most caring, humane, and effective interventions. Other writers take a cautionary stance, focusing on the problems inherent in dual or multiple relationships and favoring a strict interpretation of ethical standards aimed at regulating professional boundaries. Persuasive arguments have been made for both points of view.

Welfel (2013) points out that many ethics scholars take a stronger stance against multiple relationships than that found in codes of ethics, especially those in which one role is therapeutic. Perhaps this is because their study of the issues has made them more keenly aware of the risks. Through their work on ethics committees, licensure boards, or as expert witnesses in court cases, they may have direct knowledge of harm that has occurred.

Even when practitioners have good intentions, they may unconsciously exploit or harm clients who are vulnerable in the relationship. If the professional boundaries become blurred, there is a strong possibility that confusion, disappointment, and disillusionment will result for both parties. For these reasons, some writers caution against entering into more than one role with a client because of the potential problems involved. They advise that it is generally a good idea to avoid multiple roles unless there is sound clinical justification for considering multiple roles.

Although dual relationships are not damaging to clients in all cases, St. Germaine (1993) believes counselors must be aware that the potential for harm is always present. She states that errors in judgment often occur when the counselor's own interests become part of the equation. This loss of objectivity is one factor that increases the risk of harm.

Gabbard (1994) and Gutheil and Gabbard (1993) have warned of the dangers of the *slippery slope*. They caution that when counselors make one exception to their customary boundaries with clients, it becomes easier and easier to make more exceptions until an exception is made that causes harm. They argue that certain actions can lead to a progressive deteriora-

tion of ethical behavior. Furthermore, if professionals do not adhere to uncompromising standards, their behavior may foster relationships that are harmful to clients. Remley and Herlihy (2014) summarize this argument by stating, "The gradual erosion of the boundaries of the professional relationship can take counselors down an insidious path" (p. 206) that could even lead, ultimately, to a sexual relationship with a client.

Other writers are critical of this notion of the slippery slope, stating that it tends to result in therapists practicing in an overly cautious manner that may harm clients (Lazarus & Zur, 2002; Pope & Vasquez, 2011; Speight, 2012; Zur, 2007). Overlapping boundaries and crossing boundaries are not necessarily problematic; instead, they can be positive and beneficial within therapeutic relationships (Speight, 2012). G. Corey, Corey, Corey, and Callanan (2015) remind us that ethics codes are creations of humans, not divine decrees that contain universal truth. They do not believe dual or multiple relationships are always unethical, and they have challenged counselors to reflect honestly and think critically about the issues involved. They believe codes of ethics should be viewed as guidelines to practice rather than as rigid prescriptions and that professional judgment must play a crucial role.

Tomm (1993) has suggested that maintaining interpersonal distance focuses on the power differential and promotes an objectification of the therapeutic relationship. He suggested that dual relating invites greater authenticity and congruence from counselors and that counselors' judgments may be improved rather than impaired by dual relationships, making it more difficult to use manipulation and deception or to hide behind the protection of a professional role.

Lazarus and Zur (2002) and Zur (2014) make the point that none of the codes of ethics of any of the various professions takes the position that nonsexual dual relationships are unethical per se. They believe that "dual relationships are neither always unethical nor do they necessarily lead to harm and exploitation, nor are they always avoidable. Dual relationships can be helpful and beneficial to clients if implemented intelligently, thoughtfully, and with integrity and care" (Lazarus & Zur, 2002, p. 472). They remind counselors that dual relationships are not, in and of themselves, illegal, unethical, unprofessional, or inappropriate. Instead, unethical dual relationships are those that are reasonably likely to exploit clients or impair professional judgment.

We agree that duality itself is not unethical; rather, the core of the problem lies in the potential for the counselor to exploit clients or misuse power. Simply avoiding multiple relationships does not prevent exploitation. Counselors might deceive themselves into thinking that they cannot possibly exploit their clients if they avoid occupying more than one professional role. In reality, counselors can misuse their therapeutic power and influence in many ways and can exploit clients without engaging in dual or multiple relationships.

Some Dual or Multiple Relationships Are Unavoidable

It seems evident from the controversy over dual or multiple relationships that not all dual relationships can be avoided and that not all of these relationships are necessarily harmful or unethical. The APA (2010) states that "multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical" (3.05.a.). The key is to take steps to ensure that the practitioner's judgment is not impaired and that no exploitation or harm to the client occurs.

Perhaps some of the clearest examples of situations in which dual relationships may be unavoidable occur in the lives of rural practitioners. In an isolated, rural community the local minister, merchant, banker, beautician, pharmacist, or mechanic might be clients of a particular counselor. In such a setting, the counselor may have to play several roles and is likely to find it more difficult to maintain clear boundaries than it is for colleagues who practice in more densely populated areas. It is worth noting that "small worlds" can exist in urban as well as in rural environments. In many close-knit communities, nonprofessional contacts and relationships are likely to occur because clients often seek out counselors who share their values and are familiar with their culture. These "small worlds" might include religious congregations, those in recovery from substance abuse, the gay/lesbian/bisexual/transgender community, some racial or ethnic minority groups, and the military.

The debate over dual or multiple relationships has been extensive, and much of it has been enlightening and thought provoking. At this point, we ask you to consider where you stand.

- What is your stance toward dual or multiple relationships?
- With which of the perspectives do you most agree?
- How did you arrive at this stance?
- What do you see as its risks and benefits?

Boundary Crossings Versus Boundary Violations

Some behaviors in which professionals may engage from time to time have a *potential* for creating a problematic situation, but these behaviors are not, by themselves, dual relationships. Some examples might be accepting a small gift from a client, accepting a client's invitation to a special event such as a wedding, going out for coffee or tea with a client, making home visits to clients who are ill, or hugging a client at the end of a particularly painful session. Similar types of interactions are listed in the *ACA Code of Ethics* (ACA, 2014) as examples of "extending counseling boundaries" (Standard A.6.b.)

Some writers (Gabbard, 1995; Gutheil & Gabbard, 1993; R. I. Simon, 1992; Smith & Fitzpatrick, 1995) have suggested that such interactions might be considered boundary crossings rather than boundary violations. A *boundary violation* is a serious breach that results in exploitation or harm to clients. In contrast, a *boundary crossing* is a departure from commonly accepted practice that might benefit the client. Crossings occur when the boundary is shifted to respond to the needs of a particular client at a particular moment. Boundary crossings may even result in clinically effective interventions (Zur, 2012).

Interpersonal boundaries are not static and may be redefined over time as counselors and clients work closely together. Zur and Lazarus (2002) take the position that rigid boundaries are not in the best interests of clients. They maintain that rigidity, distance, and aloofness are in direct conflict with doing what is therapeutically helpful for clients. We agree with Zur and Lazarus's thoughts on rigid boundaries, but we also believe that even seemingly innocent behaviors can lead to dual relationship entanglements with the potential for exploitation and harm if they become part of a *pattern* of blurring professional boundaries.

Some roles that professionals play involve an *inherent duality*. One such role is that of supervisor. Supervisees often experience an emergence of earlier psychological wounds and discover some of their own unfinished business as they become involved in working with clients. Ethical supervisors do not abandon their supervisory responsibilities by becoming counselors to supervisees, but they can encourage their supervisees to view personal therapy with another professional as a way to become more effective as a counselor and as a person. At the same time, although the supervisor and therapist roles differ, personal issues arise in both relationships, and supervisors need to give careful thought as to when and how these issues should be addressed. As another example, counselor educators serve as teachers, as therapeutic agents for student growth and self-awareness, as supervisors, and as evaluators, either sequentially or simultaneously. This role blending can present ethical dilemmas involving conflicts of interest or impaired judgments.

None of these roles or behaviors actually constitutes an ongoing dual relationship of the type that is likely to lead to sanctions by an ethics committee. Nonetheless, each does involve two individuals whose power positions are not equal. Role blending is not necessarily unethical, but it does require vigilance on the part of the professional to ensure that no exploitation occurs. One of the major difficulties in dealing with dual relationship issues is the lack of clear-cut boundaries between roles. Where exactly is the boundary between a counseling relationship and a friendship? How does a counselor educator remain sensitive to the need to promote student self-understanding without inappropriately acquiring personal knowledge about the student? Can a supervisor work effectively without addressing the supervisee's personal concerns that may be impeding the

supervisee's performance? These are difficult questions, and any answers must include a consideration of the potential harm to clients, students, or supervisees when a dual relationship is initiated.

The Potential for Harm

Whatever the outcome of a dual or multiple relationship, a *potential* for harm almost always exists from the beginning of the relationship. To illustrate, let's revisit the example given earlier of a behavior that was identified as benign or even therapeutic. No apparent harm was done when the marriage counselor attended the renewal of wedding vows ceremony and reception. But what might have happened if the counselor had simply accepted the invitation without discussing with the couple any potential problems that might arise? What if the counselor had been approached at the reception and asked how she knew the couple? Had the counselor answered honestly, she would have violated the privacy of the professional relationship. Had she lied or given an evasive answer, harm to the clients would have been avoided, but the counselor could hardly have felt good about herself as an honest and ethical person.

One of the major problems with multiple relationships is the possibility of exploiting the client (or student or supervisee). Kitchener and Harding (1990) contend that dual relationships lie along a continuum from those that are potentially very harmful to those with little potential for harm. They concluded that dual relationships should be entered into only when the risks of harm are small and when there are strong, offsetting ethical benefits for the client.

How does one assess the potential for harm? Kitchener and Harding identified three factors that counselors should consider: incompatibility of expectations on the part of the client, divergence of responsibilities for the counselor, and the power differential between the parties involved.

First, the greater the incompatibility of expectations in a dual role, the greater the risk of harm. For example, John, a supervisor, is also providing personal counseling to Suzanne, his supervisee. Although Suzanne understands that evaluation is part of the supervisory relationship, she places high value on the confidentiality of the counseling relationship. John is aware that her personal problems are impeding her performance as a counselor. In his supervisory role, he is expected to serve not only Suzanne's interests but also those of the agency in which she is employed and of the public that she will eventually serve. When he shares his evaluations with her employer as his supervisory contract requires, and notes his reservations about her performance (without revealing the specific nature of her personal concerns), Suzanne feels hurt and betrayed. The supervisory behaviors to which she had agreed when she entered into supervision with John were in conflict with the expectations of confidentiality and acceptance that she had come to hold for John as her counselor.

Second, as the responsibilities associated with dual roles diverge, the potential for divided loyalties and loss of objectivity increases. When counselors also have personal, political, social, or business relationships with their clients, their self-interest may be involved and may compromise the client's best interest. For example, Lynn is a counselor in private practice who has entered into a counseling relationship with Paula, even though she and Paula are partners in a small, part-time mail order business. In the counseling relationship, Paula reveals that she is considering returning to college, which means that she will have to give up her role in the business. Lynn is faced with divided loyalties because she does not want the business to fold and she does not have the time to take it over. As this example illustrates, it is difficult to put the client's needs first when the counselor is also invested in meeting her own needs.

The third factor has to do with influence, power, and prestige. Clients, by virtue of their need for help, are in a dependent, less powerful, and more vulnerable position. For example, Darla is a counselor educator who is also counseling Joseph, a graduate student in the program. When a faculty committee meets to assess Joseph's progress, Joseph is given probationary status because his work is marginal. Although Darla assures Joseph that she revealed nothing about his personal problems during the committee meeting, Joseph's trust is destroyed. He is fearful of revealing his personal concerns in counseling with Darla because he knows that Darla will be involved in determining whether he will be allowed to continue his graduate studies at the end of his probationary period. He wants to switch to another counselor but is afraid of offending Darla. Counselor educators and counselors must be sensitive to the power and authority associated with their roles. They must resist using their power to manipulate students or clients. Because of the power differential, it is the professional's responsibility to ensure that the more vulnerable individual in the relationship is not harmed.

Risks in Dual or Multiple Relationships

The potential for harm can translate into risks to all parties involved in a dual relationship. These risks can even extend to others not directly involved in the relationship.

Risks to Consumers

Of primary concern is the risk of harm to the consumer of counseling services. Clients who believe that they have been exploited in a dual relationship are bound to feel confused, hurt, and betrayed. This erosion of trust may have lasting consequences. These clients may be reluctant to seek help from other professionals in the future. Clients may be angry about being exploited but feel trapped in a dependence on the continuing

relationship. Some clients, not clearly understanding the complex dynamics of a dual relationship, may feel guilty and wonder, "What did I do wrong?" Feelings of guilt and suppressed anger are potential outcomes when there is a power differential.

Students or supervisees, in particular, may be aware of the inappropriateness of their dual relationships yet feel that the risks are unacceptably high in confronting a professional who is also their professor or supervisor. Any of these feelings—hurt, confusion, betrayal, guilt, anger—if left unresolved could lead to depression and helplessness, the antitheses of desired counseling outcomes.

Risks to the Professional

Risks to the professional who becomes involved in a dual relationship include damage to the therapeutic relationship and, if the relationship comes to light, loss of professional credibility, charges of violations of ethical standards, suspension or revocation of license or certification, and risk of malpractice litigation. Malpractice actions against therapists are a risk when dual relationships have caused harm to the client, and the chances of such a suit being successful increase if the therapist cannot provide sound clinical justification and demonstrate that such practices are within an accepted standard of care.

Many dual or multiple relationships go undetected or unreported and never become the subject of an inquiry by an ethics committee, licensure board, or court. Nonetheless, these relationships do have an effect on the professionals involved, causing them to question their competence and diminishing their sense of moral self-hood.

Effects on Other Consumers

Dual or multiple relationships can create a ripple effect, affecting even those who are not directly involved in the relationship. This is particularly true in college counseling centers, schools, hospitals, counselor education programs, or any other relatively closed system in which other clients or students have opportunities to be aware of a dual relationship. Other clients might well resent that one client has been singled out for a special relationship. This same consideration is true in dual relationships with students and supervisees. Because a power differential is also built into the system, this resentment may be coupled with a reluctance to question the dual relationship openly for fear of reprisal. Even independent private practitioners can be subject to the ripple effect. Former clients are typically a major source of referrals. A client who has been involved in a dual relationship and who leaves that relationship feeling confused, hurt, or betrayed is not likely to recommend the counselor to friends, relatives, or colleagues.

Effects on Other Professionals

Fellow professionals who are aware of a dual or multiple relationship are placed in a difficult position. Confronting a colleague is always uncomfortable, but it is equally uncomfortable to condone the behavior through silence. This creates a distressing dilemma that can undermine the morale of any agency, center, hospital, or other system in which it occurs. Paraprofessionals or others who work in the system and who are less familiar with professional codes of ethics may be misled and develop an unfortunate impression regarding the standards of the profession.

Effects on the Profession and Society

The counseling profession itself is damaged by the unethical conduct of its members. As professionals, we have an obligation both to avoid causing harm in dual relationships and to act to prevent others from doing harm. If we fail to assume these responsibilities, our professional credibility is eroded, regulatory agencies will intervene, potential clients will be reluctant to seek counseling assistance, and fewer competent and ethical individuals will enter counselor training programs. Conscientious professionals need to remain aware not only of the potential harm to consumers but also of the ripple effect that extends the potential for harm.

Safeguards to Minimize Risks

Whenever we as professionals are operating in more than one role, and when there is potential for negative consequences, it is our responsibility to develop safeguards and measures to reduce (if not eliminate) the potential for harm. These guidelines include the following:

- Set healthy boundaries from the outset. It is a good idea for counselors to have in their professional disclosure statements or informed consent documents a description of their policy pertaining to professional versus personal, social, or business relationships. This written statement can serve as a springboard for discussion and clarification.
- Involve the client in setting the boundaries of the professional or nonprofessional relationship. Although the ultimate responsibility for avoiding problematic dual relationships rests with the professional, clients can be active partners in discussing and clarifying the nature of the relationship. It is helpful to discuss with clients what you expect of them and what they might expect of you.
- Informed consent needs to occur at the beginning of and throughout the relationship. If potential dual relationship problems arise during the counseling relationship, these should be discussed in a frank and open manner. Clients have a right to be informed about any possible risks.

- Practitioners who are involved in unavoidable dual relationships or nonprofessional relationships need to keep in mind that, despite informed consent and discussion of potential risks at the outset, unforeseen problems and conflicts can arise. Discussion and clarification may need to be an ongoing process.
- Consultation with fellow professionals can be useful in getting an objective perspective and identifying unanticipated difficulties. We encourage periodic consultation as a routine practice for professionals who are engaged in dual relationships. We also want to emphasize the importance of consulting with colleagues who hold divergent views, not just those who tend to support our own perspectives.
- When dual or multiple relationships are particularly problematic, or when the risk for harm is high, practitioners are advised to work under supervision.
- Counselor educators and supervisors can talk with students and supervisees about balance of power issues, boundary concerns, appropriate limits, purposes of the relationship, potential for abusing power, and subtle ways that harm can result from engaging in different and sometimes conflicting roles.
- Professionals are wise to document any dual relationships in their clinical case notes, more as a legal than as an ethical precaution. In particular, it is a good idea to keep a record of any actions taken to minimize the risk of harm.
- If necessary, refer the client to another professional.

Some Gray Areas

Although the *ACA Code of Ethics* (ACA, 2014) expressly forbids sexual or romantic relationships with clients or former clients, counseling close friends or family members, and engaging in personal virtual relationships with current clients, many "gray areas" remain. Do social relationships necessarily interfere with a therapeutic relationship? Some would say that counselors and clients can handle such relationships as long as the priorities are clear. For example, some peer counselors believe friendships before or during counseling are positive factors in building cohesion and trust. Others take the position that counseling and friendships do not mix well. They claim that attempting to manage a social and a professional relationship simultaneously can have a negative effect on the therapeutic process, the friendship, or both.

What about socializing with former clients, or developing a friendship with former clients? Although mental health professionals are not legally or ethically prohibited from entering into a nonsexual relationship with a client after the termination of therapy, the practice could lead to difficulties for both client and counselor. The imbalance of power may change very slowly, or not at all. Counselors should be aware of their own motivations, as

well as the motivations of their clients, when allowing a professional relationship to eventually evolve into a personal one, even after termination. When all things are considered, it is probably wise to avoid socializing with former clients.

Another relationship-oriented question relates to the appropriate limits of counselor self-disclosure with clients. Although some therapist self-disclosure can facilitate the therapeutic process, excessive or inappropriate self-disclosure can have a negative effect.

A final related issue has to do with gifts. When is it appropriate or inappropriate to accept a gift that a client has offered? These questions are explored in the following sections.

Counseling a Friend or Acquaintance

Many writers have cautioned against counseling a friend, and the *ACA Code of Ethics* (ACA, 2014) expressly prohibits counseling close friends. Kitchener and Harding (1990) point out that counseling relationships and friendships differ in function and purpose. We agree that the roles of counselor and friend are incompatible. Friends do not pay their friends a fee for listening and caring. It will be difficult for a counselor who is also a friend to avoid crossing the line between empathy and sympathy. It hurts to see a friend in pain. Because a dual relationship is created, it is possible that one of the relationships—professional or personal—will be compromised. It may be difficult for the counselor to confront the client in therapy for fear of damaging the friendship. It is also problematic for clients, who may hesitate to talk about deeper struggles for fear that their counselor/friend will lose respect for them. Counselors who are tempted to enter into a counseling relationship with a friend would do well to ask themselves whether they are willing to risk losing the friendship.

A question remains, however, as to where to draw the line. Is it ethical to counsel a mere acquaintance? A friend of a friend? A relative of a friend? We think it is going to absurd lengths to insist that counselors have *no* other relationship, prior or simultaneous, with their clients. Often clients seek us out for the very reason that we are not complete strangers. A client may have been referred by a mutual friend or might have attended a seminar given by the counselor. A number of factors may enter into the decision as to whether to counsel someone we know only slightly or indirectly.

Borys (1988) found that male therapists, therapists who lived and worked in small towns, and therapists with 30 or more years of experience all rated remote dual professional roles (as in counseling a client's friend, relative, or lover) as significantly more ethical than did a comparison group. Borys speculated that men and women receive different socialization regarding the appropriateness of intruding on or altering boundaries with the opposite sex: Men are given greater permission to take the initiative or otherwise become more socially intimate. In a rural environment

or a small town, it is difficult to avoid other relationships with clients who are likely to be one's banker, beautician, store clerk, or plumber. Perhaps more experienced therapists believe they have the professional maturity to handle dualities, or it could be that they received their training at a time when dual relationships were not the focus of much attention in counselor education programs. Whatever one's gender, work setting, or experience level, these boundary questions will arise for counselors who conduct their business and social lives in the same community.

A good question to ask is whether the nonprofessional relationship is likely to interfere, at some point, with the professional relationship. Sound professional judgment is needed to assess whether objectivity can be maintained and role conflicts avoided. Yet we need to be careful not to place too much value on "objectivity." Being objective does not imply a lack of personal caring or subjective involvement. Although it is true that we do not want to get lost in the client's world, we do need to enter this world to be effective.

A special kind of dual relationship dilemma can arise when a counselor needs counseling. Therapists are people, too, and have their own problems. Many of us will want to talk to our friends, who might be therapists, to help us sort out our problems. Our friends can be present for us in times of need and provide compassion and caring, although not in a formal therapeutic way. We will not expect to obtain long-term therapy with a friend, nor should we put our friends in a difficult position by requesting such therapy.

A related boundary consideration is how to deal with clients who want to become our friends via the Internet. It is not unusual for a counselor to receive a "Friend Request" from a client or former client. For counselors who are considering using Facebook, a host of ethical concerns about boundaries, dual relationships, and privacy are raised. Spotts-De Lazzer (2012) claims that practitioners will have to translate and maintain traditional ethics when it comes to social media. Spotts-De Lazzer offers these recommendations to help counselors manage their presence on Facebook:

- Limit what is shared online.
- Include clear and thorough social networking policies as part of the informed consent process.
- Regularly update protective settings because Facebook options are constantly changing.

Zur and Zur (2011) have outlined a number of questions therapists should reflect on before agreeing to become involved as a friend on Facebook or some other form of social media. Some of these questions include:

- What is on the Facebook profile?
- What is the context of counseling?

- Who is the client, and what is the nature of the therapeutic relationship?
- Why did the client post the request?
- What is the meaning of the request?
- Where is the counseling taking place?
- What does being a "Friend" with this client mean for the therapist and for the client?
- What are the ramifications of accepting a Friend Request from a client for confidentiality, privacy, and record keeping?
- Does accepting a Friend Request from a client constitute a dual relationship?
- How will accepting the request affect treatment and the therapeutic relationship?

As is evident by considering this list of questions, the issue of whether or not to accept a client's Friend Request is quite complex and requires careful reflection and consultation. To read more about this topic, visit the Zur Institute at http://www.zurinstitute.com/.

Socializing With Current Clients

Socializing with current clients may be an example of a boundary crossing if it occurs inadvertently or infrequently or of an inappropriate dual relationship, depending on the nature of the socializing. A social relationship can easily complicate keeping a therapeutic relationship on course. Caution is recommended when it comes to establishing social relationships with former clients, and increased caution is needed before blending social and professional relationships with current clients. Among Borys's (1988) findings were that 92% of respondents believed that it was never or only rarely ethical to invite clients to a personal party or social event; 81% gave these negative ratings to going out to eat with a client after a session. Respondents felt less strongly about inviting clients to an office or clinic open house (51% viewed this as never or rarely ethical) or accepting a client's invitation to a special occasion (33%).

One important factor in determining how therapists perceive social relationships with clients may be their theoretical orientation. Borys found psychodynamic practitioners to be the most concerned about maintaining professional boundaries. One reason given for these practitioners' opposition to dual role behaviors was that their training promotes greater awareness of the importance of clear, nonexploitive, and therapeutically oriented roles and boundaries. In the psychodynamic view, transference phenomena give additional meaning to alterations in boundaries for both client and therapist. A further explanation is that psychodynamic theory and supervision stress an informed and scrupulous awareness of the role the therapist plays in the psychological life of the client—namely, the importance of "maintaining the frame of therapy."

A counselor's stance toward socializing with clients appears to depend on several factors. One is the nature of the social function. It may be more acceptable to attend a client's special event such as a wedding than to invite a client to a party at the counselor's home. The orientation of the practitioner is also a factor to consider. Some relationship-oriented therapists might be willing to attend a client's graduation party, for instance, but a psychoanalytic practitioner might feel uncomfortable accepting an invitation for any out of the office social function. This illustrates how difficult it is to come up with blanket policies to cover all situations.

- What are your views about socializing with current clients?
- Do you think your theoretical orientation influences your views?
- Under what circumstances might you have contact with a client out of the office?

Social Relationships With Former Clients

Having considered the matter of socializing with current clients, we now look at posttermination social relationships between counselors and clients. Few professional codes specifically mention social relationships with former clients. An exception is the Canadian Counselling and Psychotherapy Association (2007) code of ethics:

> Counsellors remain accountable for any relationships established with former clients. Those relationships could include, but are not limited to those of a friendship, social, financial, and business nature. Counsellors exercise caution about entering any such relationships and take into account whether or not the issues and relational dynamics present during the counselling have been fully resolved and properly terminated. In any case, counsellors seek consultation on such decisions. (B.11.)

In the first edition of this book, we noted that Kitchener (1992) described the nature of the relationship once the therapeutic contract has been terminated as one of the most confusing issues for counselors and their clients. Clients may fantasize that their counselors will somehow remain a significant part of their lives as surrogate parents or friends. Counselors are sometimes ambivalent about the possibility of continuing a relationship because they are aware of real attributes of clients that under other circumstances might make them desirable friends, colleagues, or peers.

Nonetheless, there are real risks that need to be considered. Studies have suggested that memories of the therapeutic relationship remain important to clients for extended periods after termination and that many clients consider reentering therapy with their former therapists (Vasquez,

1991). This reentry option is closed if other relationships have ensued. Kitchener (1992) maintains that the welfare of the former client and the gains that have been made in counseling are put at risk when new relationships are added to the former therapeutic one. Kitchener suggests that many of the same dynamics may be operating in nonsexual posttherapy relationships as in sexual ones, although not at the same level of emotional intensity. Her conclusion is that counselors should approach the question of posttherapy relationships with care and with awareness of their strong ethical responsibility to avoid undoing what they and their clients have worked so hard to accomplish.

Two studies reveal that there is little consensus among therapists regarding whether nonromantic relationships between therapists and former clients are ethical. The majority of the participants in a study by Anderson and Kitchener (1996) did not hold to the concept of "once a client, always a client" with respect to nonsexual posttherapy relationships. Some participants suggested that posttherapy relationships were ethical if a certain time period had elapsed. Others proposed that such relationships were ethical if the former client decided not to return to therapy with the former therapist and if the posttherapy relationship did not seem to hinder later therapy with different therapists.

Another study by Salisbury and Kinnier (1996) found similar results regarding counselors' behaviors and attitudes regarding friendships with former clients. The major finding was that many counselors are engaged in posttermination friendships and believe that under certain circumstances such relationships are acceptable. Seventy percent of the counselors believed that posttermination friendships were ethical approximately 2 years after termination of the professional relationship. Although most codes of ethics now specify a minimum waiting period for sexual relationships with former clients, the codes do not address the issue of friendships with former clients.

In reviewing the codes of ethics of the various professional organizations, it appears that entering into social relationships with former clients is not considered unethical, yet the practice could become problematic. The safest policy is probably to avoid developing social relationships with former clients. Even after the termination of a therapeutic relationship, former clients may need or want our professional services at some future time, which would be ruled out if a social relationship has been established.

- What are your thoughts about social relationships with former clients?
- Do you think codes of ethics should specifically address nonromantic and nonsexual posttherapy relationships?
- Under what circumstances might such relationships be unethical?
- When might you consider them to be ethical?

A Contributor's Perspective

Ed Neukrug presents a personal perspective on a study he and a colleague conducted in 2011 on counselors' perceptions of ethical and unethical behaviors. Participants rated 77 behaviors, and many of these behaviors pertained to boundary issues.

Making Ethical Decisions When Faced With Thorny Boundary Issues

Ed Neukrug

In 1993 Gibson and Pope published the results of a study that asked counselors to identify whether they believed 88 counselor behaviors were ethical or unethical. The questions highlighted the kinds of behaviors with which counselors struggle, and I included the results in two editions of my book *The World of the Counselor* (Neukrug, 2012). In 2011, with the fourth edition of the book ready to be written, I realized that a 1993 study was a bit old. Fascinated with the original research, I decided to update the study with a colleague of mine. In 2011 the new study was published, and soon after I added the results to the new edition of my book.

The updated version of the study identified 77 behaviors (see Neukrug & Milliken, 2011). Although we kept some of the original items from the Gibson and Pope study, we did not include items for which there had been close to 100% agreement by counselors in the original study. For instance, we did not ask if it was ethical to have sex with clients or to work while drunk. In the original study, just about every counselor felt strongly that those behaviors were unethical, and we knew from years of teaching that counselors had a clear understanding that behaviors such as these were unethical. We wanted to make sure the new survey reflected current codes. For instance, since 1993 the *ACA Code of Ethics* has twice been revised, with the latest *Code* replacing the term *clear and eminent danger* with *serious and foreseeable harm*; increasing restrictions on romantic and sexual relationships; including a statement on the permissibility of end-of-life counseling for terminally ill clients; increasing attention to social and cultural issues; allowing counselors to refrain from making a diagnosis; highlighting the importance of having a scientific basis for treatment; requiring counselors to have a transfer plan for clients; adding technology guidelines; including a statement about the right to confidentiality for deceased clients; and softening the permissibility of dual relationships, now often referred to as multiple relationships (ACA, 2005; Kaplan et al., 2009).

The new survey kept about one third of the original items, revised about one third of the original items, and included about one third new items that reflected changes since 1993. The new survey asked counselors to identify whether each of the 77 counselor behaviors were ethical or not ethical and to rate each counselor behavior on a 10-point Likert-type scale indicating

how strongly they felt about their responses (1 = *not very strongly*, 10 = *very strongly*). In addition, the new survey asked counselors whether they had received ethics training in their program or elsewhere. Here we found some interesting results compared to the Gibson and Pope (1993) study.

Whereas Gibson and Pope found 73% of respondents had ethics training, a resounding 97.8% of counselors in our survey stated they had ethics training. Similarly, whereas 29% of counselors in the Gibson and Pope study reported taking a formal ethics course, this study found 60% had taken one ethics course, and 60% had taken more than one ethics course. In addition, a similar number stated that ethics training was infused throughout their program. The increase in ethics training demonstrates a major shift nationally and is likely the result of a number of changes. For instance, the increase in the number of programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) has undoubtedly affected these statistics because CACREP requires students to learn about ethics (CACREP, 2009; Urofsky & Sowa, 2004). This growth in ethics training is probably also the result of credentialing boards increasingly requiring ethics training when professionals obtain or renew their credentials (National Board for Certified Counselors, 2012). Also, as society has become increasingly litigious, the importance of ethics training to avoid malpractice lawsuits has become paramount (Neukrug, Milliken, & Walden, 2001; Remley & Herlihy, 2014; Saunders, Barros-Bailey, Rudman, Dew, & Garcia, 2007). Finally, this greater focus on ethics training has probably fostered a surge in scholarly materials (e.g., journal articles) that increase knowledge of ethics among professionals.

Counselor Perceptions of Boundary Crossings

There is an expectation placed on counselors to maintain the sanctity of the counseling relationship by maintaining boundaries between themselves and the clients they serve (Remley & Herlihy, 2014). Our ethics codes tend to support this perspective, highlighting behaviors that should be avoided to protect our clients from injury. Our professional associations expect counselors to exhibit certain behaviors that respect boundaries between counselors and clients, and clients generally have a fairly good sense of what is "right and wrong" within the relationship regarding boundaries. Of course, it helps if clients have a clear understanding of these boundaries, and counselors can provide clients with an informed consent statement that addresses issues of boundaries in the relationship and the ethics code from the counselor's professional association.

Despite expectations from our professional associations and dictates from our ethics codes, many boundary issues are complicated, and, as noted earlier in the chapter, sometimes an intentional and thoughtful boundary crossing can be helpful to the counseling relationship (G. Corey et al., 2015; Moleski & Kiselica, 2005; Zur, 2007). Although our survey examined

counselors' beliefs regarding a wide range of behaviors, a number of items specifically addressed boundary issues, the focus of this book. We have teased out those items and present them in Table 1.1. For the complete study results, see Neukrug and Milliken (2011).

Context Is Everything

In reviewing Table 1.1, it is clear that many counselors believe certain behaviors to be acceptable even though they will affect the boundary between counselor and client. For instance, more than 85% of counselors believed these behaviors are ethical: "breaking confidentiality if the client is threatening harm to self," "having clients address you by your first name," "using an interpreter when a client's primary language is different from yours," and "self-disclosing to a client." However, even when the vast majority of counselors believe a behavior to be ethical, their actual responses may vary dramatically as a function of the context. For instance, a counselor doesn't break confidentiality in all cases of potential "harm to self." Rather, the decision depends on the seriousness of the thoughts, the likelihood of the action, and the means available to the client. Similarly, although many counselors may feel comfortable having clients address them by their first names, in some cases, depending on the professional style of the counselor or the issues of the client (a client who has boundary issues in his or her life), a counselor may decide it is important for a client to not address the counselor by his or her first name. Although it may be acceptable and even important to use an interpreter in a counseling relationship, a counselor must consider whether the interpreter is trustworthy and can keep the conversation confidential and how the use of an interpreter might affect the willingness of the client to discuss embarrassing or shameful material. It may be better to refer this client to a person who speaks the client's language. Finally, although incidental self-disclosures such as "I'm so proud of you" or "I love your outfit today" can add to the working alliance, we are all aware that inappropriate self-disclosures that reveal too much about the counselor, or are done for the wrong reasons, can wreak havoc in the helping relationship.

Similarly, most counselors believe a number of behaviors are unethical most of the time and would negatively affect the boundary within the helping relationship if practiced. But even here context is everything, and a counselor might decide to exhibit the behavior in certain circumstances. Consider the following behaviors from Table 1.1 that most counselors view as unethical. Then look at the corresponding counselor situation in which exhibiting such a behavior might be acceptable.

Item 20: Trying to change your client's values

A counselor working with a client who uses corporal punishment suggests other ways that the client can parent, shows her "positive parenting" techniques, and points out the research regarding the effectiveness of positive parenting and the ineffectiveness of corporal punishment.

Table 1.1 Counselors' Perceptions Regarding Boundary Issues

Item Number and Behavior	Percentage		Strength of Response	
	Ethical	Unethical	*M*	*SD*
1. Breaking confidentiality if the client is threatening harm to self	95.7	4.3	8.73	3.6
2. Having clients address you by your first name	94.9	5.1	7.41	3.9
3. Using an interpreter when a client's primary language is different from yours	88.8	11.2	5.4	5.0
4. Self-disclosing to a client	86.8	13.2	4.4	4.7
5. Consoling your client by touching him or her (e.g., placing your hand on his or her shoulder)	83.9	16.1	4.5	5.2
6. Publicly advocating for a controversial cause	83.6	16.4	4.2	5.4
7. Attending a client's wedding, graduation ceremony, or other formal ceremony	72.1	27.9	2.2	5.8
8. Hugging a client	66.7)	33.3	1.7	5.5
9. Counseling a pregnant teenager without parental consent	62.0	38.0	1.5	6.7
10. Telling your client you are angry at him or her	61.5	38.5	1.0	6.7
11. Withholding information about a minor client despite a parent's request for information	47.4	52.6	–0.7	6.8
12. Pressuring a client to receive needed services	43.3	56.7	–0.9	6.4
13. Becoming sexually involved with a former client (at least 5 years after the counseling relationship ended)	42.9	57.1	–2.1	6.8
14. Guaranteeing confidentiality for group members	36.9	63.1	–2.1	7.5
15. Sharing confidential client information with a colleague who is not your supervisor	29.4	70.6	–3.5	6.7
16. Engaging in a helping relationship with a client (e.g., individual counseling) while the client is in another helping relationship (e.g., family counseling) without contacting the other counselor	26.8	73.2	–4.0	6.2
17. Seeing a minor client without parental consent	25.4	74.6	–4.3	6.2
18. Viewing your client's personal Web page (e.g., MySpace, Facebook, blog) without informing your client	22.5	77.5	–4.7	5.8
19. Becoming sexually involved with a person your client knows well	22.3	77.7	–5.1	5.9
20. Trying to change your client's values	13.4	86.6	–6.5	5.3
21. Kissing a client as a friendly gesture (e.g., greeting)	12.5	87.5	–6.6	4.6
22. Accepting a gift worth more than $25 from a client	11.7	88.3	–6.1	4.6
23. Revealing confidential information if a client is deceased	11.6	88.4	–6.0	4.5
24. Engaging in a professional counseling relationship with a colleague who works with you	10.7	89.3	–7.8	3.7
25. Engaging in a dual relationship (e.g., your client is also your child's teacher)	10.4	89.6	–6.6	4.6
26. Telling your client you are attracted to him or her	10.3	89.7	–7.6	4.6
27. Giving a gift worth more than $25 to a client	5.3	94.7	–7.5	3.7
28. Engaging in a professional counseling relationship with a friend	4.6	95.4	–7.8	3.6
29. Lending money to your client	3.4	96.6	–8.3	3.1
30. Revealing a client's record to the spouse of a client without the client's permission	0.6	99.4	–9.2	2.1
31. Attempting to persuade your client to adopt a religious conviction you hold	0.6	99.4	–9.2	2.0

Item 21: Kissing a client as a friendly gesture (e.g., greeting)
A counselor and client share a cultural heritage in which a kiss on the cheek is usual and expected.

Item 22: Accepting a gift worth more than $25 from a client
A client who is terminating counseling after years of work with a counselor gives the counselor a $30 book as a thank-you for their work together.

Item 24: Engaging in a professional counseling relationship with a colleague who works with you
The only counselor in an area practicing a neuroprocessing technique to relieve stress migraines is asked by a coworker to work with him for the three sessions needed to learn the process.

Item 25: Engaging in a dual relationship (e.g., your client is also your child's teacher)
A new client comes to counseling and the counselor realizes that the two of them are in the same exercise class. Together, they decide they can manage the dual relationship.

Item 26: Telling your client you are attracted to him or her
Having worked with a depressed client for a while who has recently made some significant changes, a counselor says, "You have such an attractive smile when your depression lifts."

Item 27: Giving a gift worth more than $25 to a client
A client with whom you have worked has focused on improving her life. One area in which she has worked long and hard is obtaining her general equivalency diploma (GED). After 2 years of hard work, she obtains her GED. You decide to have her diploma framed as a reinforcement of her hard work.

Reflecting on Context

Despite the fact that the behaviors just discussed were seen as mostly ethical (Items 1–5) or mostly unethical (Items 20–27) by the vast majority of counselors, responses can still vary as a function of context. In our survey, counselors had a fair amount of disagreement regarding whether some items were ethical or unethical (Items 5–19). These behaviors represent situations in which counselors might struggle. Keeping context in mind, review these behaviors and consider when you believe it might be appropriate or inappropriate to exhibit the behaviors. Finally, you might also want to tackle the last four items (Items 28–31) and consider whether there is ever a time when such behaviors might be ethical.

Ethical decision making around boundary issues can be a complex and difficult process, and responses may not always be as obvious as we might expect. Knowing your client, yourself, and the context of the particular ethical dilemma can help you make a wise decision in the client's best interests.

A Contributor's Perspective

Arnold A. Lazarus presents a provocative argument that strict boundary regulations may have a negative impact on therapeutic outcomes. He encourages therapists to avoid practicing defensively and to be willing to think and venture outside the proverbial box.

Transcending Boundaries in Psychotherapy

Arnold A. Lazarus

When I was an undergraduate student in South Africa (1951–1955), the dominant ethos was Freudian psychoanalysis. Most of the books and articles we read were authored by Freud or his followers. Practitioners endeavored to remain a "blank screen" to their patients or "analysands." They avoided any self-disclosures, and all communications were strictly confined to the office or consulting room, which contained nothing personal—no diplomas, no family photos—and the only furniture was a couch, a desk, and some chairs. For the analyst to become the "screen" on which the patient projects fantasies and feelings during the transference process, he or she remains passive and neutral. This permits the patient to feel free to voice his or her private and innermost ideas and attitudes without interference by the personality of the analyst.

Some of the practitioners were so rigid that if they walked into a restaurant and saw one of their analysands they would leave immediately. Even when the field became more eclectic, many analytic proscriptions and prohibitions spilled over and were adopted by most therapists. Subsequently, when rules of ethics were first drawn up, any form of fraternization with a client was frowned upon, and dual relationships were considered taboo. During my internship in 1957 two of my peers were severely reprimanded: one for sharing tea and cookies with a client, and the other for helping a woman on with her coat.

As my orientation became behavioral and the theories and methods I applied differed significantly from psychoanalytic and psychodynamic approaches, I argued that there was no need to subscribe to their rules of client–therapist interaction. Far from being a "screen," I was a fellow human being who considered it important to treat clients with dignity, respect, decency, and equality. Indeed, "breaking bread" with some clients fostered closer rapport, as did some out-of-office experiences such as driving a client to the train station on a cold rainy day. It always struck me as very impolite, if not insulting, to answer a question with a question instead of answering the question and then inquiring why that issue had been raised. One of my clients complained that when he asked his psychodynamic therapist a noninvasive and not too personal question she said, "We are not here to discuss me." He said he felt demeaned and terminated the therapy soon thereafter.

To balance the playing field, it is necessary to remember that most rules have exceptions, and it is essential to observe certain caveats. There are clients with whom clear-cut boundaries are necessary. People who fit into certain diagnostic categories or evince certain behaviors require a definite structure and clear-cut boundaries: for example, those with psychoses, bipolar depression, borderline personalities, antisocial tendencies, substance abuse, histrionic personality disorders, character pathology, suicidal behaviors, eating disorders (especially anorexia nervosa), self-injurious behaviors, or criminal proclivities. A definite structure and clear-cut boundaries are not an invitation to mete out or exhibit nonempathic behavior, impolite comments, judgmental statements, or insulting remarks. The reason I am underscoring these issues is because many people have erroneously concluded that I am advocating a laissez-faire and capricious fraternization with all clients. It is necessary to be wary and well informed before deciding that it would be in the client's best interests to stretch or cross certain boundaries. I am opposed to clinicians who treat all their clients in the same way and always go by the book. I reiterate that while deciding whether or not to traverse demarcated boundaries, if one has any misgivings, it is best to err on the side of caution.

A prevalent practice that tends to handicap therapists and often leads them to harm rather than to help certain clients or patients is therapists' insistence on maintaining strict boundaries. They practice defensively, guided by their fear of licensing boards and attorneys rather than by clinical considerations. Risk management seminars typically warn therapists that if they cross boundaries severely negative consequences from licensing boards and ethics committees are likely to ensue. For example, they are warned not to fraternize or socialize with clients and are told to steer clear of any mutual business transactions (other than the fee for service). They are advised to avoid bartering and to avoid working with or seeing a client outside the office. Yet those therapists who transcend certain boundaries with selected clients often provide superior help. They rely on their own judgment and refuse to hide behind barriers or to function within a metaphorical straitjacket. Great benefits can accrue when therapists are willing to think and venture outside the proverbial box. Here is a case in point.

> Paul, aged 17, required help for some potentially serious drug problems. His parents had tried to find a therapist who could treat and assist him, but to no avail. Paul had initial meetings with four different therapists over a 6-week interval but declared each one "a jerk" and refused to go back. He then reluctantly consulted a fifth therapist (who had been one of my recent postdoctoral students) who quickly sized up the situation. He realized that Paul would regard any formal meeting with a professional therapist as reminiscent of his uptight parents and strict teachers, so he would resist their ministrations. The therapist cleverly stepped out of role and invited Paul to shoot some baskets with him later that day at a nearby basketball court. It

> took several weeks of basketball playing and informal chatting before adequate rapport and trust were established, at which point Paul was willing to engage in formal office visits and seriously address his problems.

This innovative, free-thinking, and creative therapist was willing to take a risk and cross a boundary, and in so doing he gained the trust of a young man who was really hurting emotionally. This enabled Paul to respond to the therapist as a kind and accomplished big brother he could look up to and from whom he could learn a good deal.

Why have psychotherapists found it necessary to form ethics committees; establish a wide range of principled dos and don'ts; and police, discipline, and penalize those who cross the line? This is probably in response to the extreme laissez-faire climate of therapeutic interaction that prevailed in the 1950s and 1960s, when blatant boundary crossings were openly espoused. For example, at Esalen in California, where Frederick (Fritz) Perls and his associates established a training and therapy institute, therapists and clients often became playmates and even lovers. It is not far fetched to look upon many of their dealings as flagrant acts of malpractice. Concerned professionals became aware of the emotional damage that was being wrought in many settings and sought to establish a code of ethics and to lay down basic ground rules for practitioners. Terms like *boundaries*, *boundary violation*, and *standard of care* entered the vernacular.

Today, all therapists are expected to treat their clients with respect, dignity, and consideration and to adhere to the spoken and unspoken rules that make up our established standards of care. Many of these rules are necessary and sensible. For instance, it is essential for therapists to avoid any form of exploitation, harassment, harm, or discrimination, and it is understandable that a sexual relationship with a client is considered an ultimate taboo. Emphasis is placed on the significance of respect, integrity, confidentiality, and informed consent. Nevertheless, some elements of our ethics codes have become so needlessly stringent and rigid that they can undermine effective therapy. The pendulum has swung too far in the opposite direction from the era of negligent free-for-all indulgence.

One of my major concerns is that there is a widespread failure to grasp the critical difference between "boundary violations," which can harm a client, and "boundary crossings," which produce no harm and may even enhance the therapeutic connection. For example, what would be so appalling about a therapist saying to a client who has just been seen from 11 a.m. until noon: "We seem to be onto something important. Should we go and pick up some sandwiches at the local deli, and continue until 1 p.m. at no extra fee to you?" Strict boundary proponents would regard such behavior as unethical because it goes outside the therapeutic frame. However, strategic therapists would argue that rigid adherence to a particular frame and setting only exacerbates problems, especially in nonresponsive patients. For

example, a patient of mine who had been resistant and rather hostile arrived early for his appointment. I was just finishing lunch and had some extra sandwiches on hand, so I offered him one. He accepted my offer as well as a glass of orange juice. Coincidentally or otherwise, thereafter our rapport was greatly enhanced, and he made significant progress. What became clear during our ensuing sessions was that the act of literally breaking bread led him to perceive me as humane and caring and facilitated his trust in me.

Over the past 40 years, I have seen thousands of clients and have selectively transcended boundaries on many occasions. For example, I engaged in barter with an auto mechanic, who tuned my car in exchange for three therapy sessions. I have accepted dinner invitations from some clients, have attended social functions with others, played tennis with several clients, and ended up becoming good friends with a few. Of course, I do not engage in such behaviors capriciously. Roles and expectations must be clear. Possible power differentials must be kept in mind. For my own protection as well as the client's protection, I don't engage in these behaviors with seriously disturbed people, especially those who are hostile, paranoid, aggressive, or manipulative. But the antiseptic obsession with "risk management" has led far too many therapists to practice their craft in a manner that is needlessly constraining and often countertherapeutic.

Those therapists who rigidly adhere to strict professional boundaries are apt to place risk management ahead of humane interventions. The manner in which they speak to their clients often leaves much to be desired. For example, I recently attended a clinical meeting at which a young psychiatrist was interviewing a woman who suffered from an eating disorder, bulimia nervosa. At one point the dialogue continued more or less as follows:

Patient: May I ask how old you are?
Therapist: Why is that important?
Patient: It's no big deal. I was just curious.
Therapist: Why would you be curious about my age?
Patient: Well, you look around 30, and I was just wondering if I am correct.
Therapist: What impact would it have if you were not correct?
Patient: None that I can think of. It was just idle curiosity.
Therapist: Just idle curiosity?

As I watched these exchanges, I grew uncomfortable. It seemed to me that the patient wished she had never raised the issue in the first place and that she was feeling more and more uneasy. It did not seem that the dialogue was fostering warmth, trust, or rapport. On the contrary, it resembled a cross-examination in a courtroom and appeared adversarial.

In psychoanalysis it is deemed important for the analyst to remain neutral and nondisclosing so the patient can project his or her needs, wishes, and fantasies onto a "blank screen." But it makes no sense for this to be-

come a rule for *all* therapists to follow. It has always struck me as ill mannered and discourteous to treat people this way.

I recommend the following type of exchange in place of the aforementioned example:

Patient: How old are you?
Therapist: I just turned 30. Why do you ask?
Patient: I was just curious. It's no big deal.
Therapist: Might you be more comfortable with or have greater confidence in someone younger or older?
Patient: No, not at all.

At this juncture, I would suggest that the topic be dropped. Notice the recommended format. First answer the question and then proceed with an inquiry if necessary. In this way, the patient is validated and not demeaned. Why am I dwelling on such a seemingly trivial issue? Because it is not a minor or frivolous point, and I have observed this type of interaction far too often, usually to the detriment of the therapeutic process. I see it as part and parcel of a dehumanizing penchant among the many rigid thinkers in our field who legislate against all boundary extensions. These are the members of our profession (and they are not a minority) who regard themselves as superior to patients and tend to infantilize and demean them in the process.

The purpose of this essay is to alert readers to an issue that is crucial in the field of psychotherapy. I have coedited a book (Lazarus & Zur, 2002) on the subject of boundaries and boundary crossings in which various contributors have addressed the topic from many viewpoints: nonanalytic practice procedures, feminist perspectives, military psychology, counseling centers, deaf communities, legal issues, gay communities, and rural settings (among others). It is generally agreed that the client–therapist relationship is at the core of treatment effectiveness. Yet by adhering to strict boundary regulations, many troublesome feelings are likely to arise and ruptures to emerge that destroy the necessary sense of trust and empathy. Greenspan (2002) aptly describes strict boundary adherence as a "distance model" that undermines the true healing potential of the work we do. I fully concur with her opinion that we need an approach of respectful compassion. Safe connection between therapist and client should be the overriding aim because this, not strict boundaries, will protect clients from abuse.

Conclusions

In this introductory chapter, we have examined what the codes of ethics of the major professional associations advise with respect to dual or multiple relationships. We have explored a number of factors that

make such relationships problematic, as well as factors that create a potential for harm and the risks to parties directly or not directly involved in multiple relationships. Some strategies for reducing risks were described.

It is critical that counselors give careful thought to the potential complications before they become entangled in ethically questionable relationships. The importance of consultation in working through these issues cannot be overemphasized. As with any complex ethical issue, complete agreement may never be reached, nor is it necessarily desirable. However, as conscientious professionals, we need to strive to clarify our own stance and develop our own guidelines for practice within the limits of codes of ethics and current knowledge.

Chapter 2

Sexual Dual Relationships

Sexual dual relationships with clients are among the most serious of all boundary violations because they involve an abuse of power and a betrayal of trust that can have devastating effects on clients. Later in this chapter we describe in some detail the harm to clients that such violations can cause. The consequences for counselors who engage in sexual misconduct with their clients also can be severe: They may have their license or certification revoked, be expelled from professional associations, be restricted in or lose their insurance coverage, be fired from their job, be sued in civil court for malpractice, or be convicted of a felony.

Sexual improprieties also undoubtedly have a negative impact on the profession. Publicity about such occurrences is likely to make potential consumers more reluctant to seek counseling services and certainly does not help mental health professionals to persuade legislators, government regulators, and health insurance companies of the value of our services (Welfel, 2013). Because sexual relationships with clients are such serious violations, they deserve careful attention. In this chapter we focus specifically on sexual dual relationships and address these questions:

- How do professional codes of ethics address sexual relationships with clients?
- What are the ethics of sexual relationships with former clients?
- How widespread is the practice of engaging in sex with current and former clients?
- Is there a "typical" offending therapist?
- What are the legal sanctions against these behaviors?
- What makes sexual dual relationships particularly harmful to clients?
- How can counselors deal appropriately with sexual attraction to clients?

- What are some appropriate and clinically useful ways to deal with a client's attraction to the counselor?
- What steps can our profession take to increase awareness of problems involved in sexual misconduct and prevent this occurrence?
- What are some legal perspectives pertaining to sexual dual relationships?

A Contributor's Perspective

To frame the discussion of topics to be explored in this chapter, we begin with Mary Hermann's perspective on the legal issues surrounding dual relationships. She makes it clear that if clients can prove they were emotionally harmed because of a dual relationship, they could prevail in a malpractice lawsuit against the counselor.

Ethical and Legal Perspectives on Sexual Dual Relationships

Mary A. Hermann

Counselors' legal liability related to dual relationships emanates from legal responsibilities associated with the counselor–client relationship. Courts have characterized the counselor–client relationship as fiduciary in nature (Douglass, 1994), a relationship in which one party places trust and confidence in another party who has power or influence (Garner & Black, 2004). As Wheeler and Bertram (2012) note, the "complexity, the power differential, and in some cases the vulnerability of counseling clients demand that we exercise extraordinary care to ensure that we are taking steps to define and respect the boundary between ourselves and our clients" (p. 135).

From a legal perspective, it is significant that dual relationships exist on a continuum ranging from boundary crossings for the benefit of the client to sexual dual relationships that can cause major trauma to the client. The legal implications of engaging in dual relationships vary, depending on the nature of the relationship and whether the client suffers harm. Thus the mere existence of a dual relationship does not, in itself, constitute malpractice. If a dual relationship is nonsexual and is managed effectively, it may have no negative impact on the counseling relationship, and no cause of action against the counselor would exist. However, if the client suffered harm because of a dual relationship such as that caused by sexual intimacy, the counselor could be sanctioned for violating legal and ethical standards.

Ethical Standards: Sexual Relations With Current Clients

Virtually all the professional codes of ethics prohibit sexual intimacies with current clients. Many of the codes also specify that if therapists have had a prior sexual relationship with a person, they must not accept this person as a client. Relevant ethical standards for counselors, psychologists, social workers, and marriage and family therapists include the following:

- Sexual and/or romantic counselor–client interactions or relationships with current clients, their romantic partners, or their family members are prohibited. This prohibition applies to both in-person and electronic interactions or relationships. (American Counseling Association [ACA], 2014, Standard A.5.a.)
- The requirement that the physician conduct himself/herself with propriety in his or her profession and in all the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification. Further, the necessary intensity of the treatment relationship may tend to activate sexual and other needs and fantasies on the part of both patient and psychiatrist, while weakening the objectivity necessary for control. Additionally, the inherent inequality in the doctor-patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient is unethical. (American Psychiatric Association, 2013b, 2.1)
- Psychologists do not engage in sexual intimacies with current therapy clients/patients. (American Psychological Association [APA], 2010, 10.05.)
- Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies. (APA, 2010, 10.07(a).)
- Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced. (National Association of Social Workers [NASW], 2008, 1.09.a.)
- Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries. (NASW, 2008, 1.09.d.)
- Sexual intimacy with current clients, or their spouses or partners is prohibited. Engaging in sexual intimacy with individuals who are known to be close relatives, guardians or significant others of current clients is prohibited. (American Association of Marriage and Family Therapists [AAMFT], 2012, 1.4.).

There is clear consensus among the professional associations that concurrent sexual and professional relationships are unethical, and many of the associations agree that a sexual relationship cannot later be converted into a therapeutic relationship. Is there similar consensus regarding the issue of converting a therapeutic relationship into a sexual one once the professional relationship has been terminated? This issue is examined next.

Ethical Standards: Sexual Relationships With Former Clients

At one time, the codes of ethics of the professional associations were silent on the issue of whether sexual relationships with former clients are ever acceptable. That situation has changed. Today the various associations specifically address this topic:

> Sexual and/or romantic counselor–client interactions or relationships with former clients, their romantic partners, or their family members are prohibited for a period of 5 years following the last professional contact. This prohibition applies to both in-person and electronic interactions or relationships. Counselors, before engaging in sexual and/or romantic interactions or relationships with former clients, their romantic partners, or their family members, demonstrate forethought and document (in written form) whether the interaction or relationship can be viewed as exploitive in any way and/or whether there is still potential to harm the former client; in cases of potential exploitation and/or harm, the counselor avoids entering into such an interaction or relationship. (ACA, 2014, Standard A.5.c.)

> Counsellors avoid any type of sexual intimacies with clients and they do not counsel persons with whom they have had a sexual relationship. Counsellors do not engage in sexual intimacies with former clients within a minimum of three years after terminating the counselling relationship. This prohibition is not limited to the three year period but extends indefinitely if the client is clearly vulnerable, by reason of emotional or cognitive disorder, to exploitative influence by the counselor. Counsellors, in all such circumstances, clearly bear the burden to ensure that no such exploitative influence has occurred, and to seek consultative assistance. (Canadian Counselling and Psychotherapy Association [CCA], 2007, B12.)

> (a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.
> (b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a post-termination sexual or romantic relationship with the client/patient. (APA, 2010, 10.08.)

> Sexual or romantic rehabilitation counselor–client interactions or relationships with former clients, their romantic partners, or their immediate family members are prohibited for a period of five years following the last professional contact. Even after five years, rehabilitation counselors give careful consideration to the potential for sexual or romantic relationships to cause harm to former clients. In cases of potential exploitation and/or harm, rehabilitation counselors avoid entering such interactions or relationships. (Commission on Rehabilitation Counselor Certification [CRCC], 2010, A.5.b.)

> Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally. (NASW, 2008, 1.09.c.)

> Sexual intimacy with former clients, their spouses or partners, or individuals who are known to be close relatives, guardians or significant other of clients is likely to be harmful and is therefore prohibited for two years following the termination of therapy or last professional contact. After the two years following the last professional contact or termination, in an effort to avoid exploiting the trust and dependency of clients, marriage and family therapists should not engage in sexual intimacy with former clients, or their spouses or partners. If therapists engage in sexual intimacy with former clients, or their spouses or partners, more than two years after termination or last professional contact, the burden shifts to the therapist to demonstrate that there has been no exploitation or injury to the former client, or their spouse or partner. (AAMFT, 2012, 1.5.)

APA (2010) and AAMFT (2012) agree that sexual contact before 2 years after termination is unethical. CCA (2007) specifies a ban on sexual intimacies for a minimum of 3 years after termination of therapy. ACA (2014) and CRCC (2010) have a minimum waiting period of 5 years following termination. NASW (2008) prohibits its members from engaging in sexual relationships with former clients regardless of time elapsed. Most of the professional organizations state that in the exceptional circumstance of sexual relationships with former clients—even after a 2- to 5-year interval—the burden of demonstrating that there has been no exploitation clearly rests with the therapist. The factors that need to be considered include the amount of time that has passed since termination of therapy, the nature and duration of therapy, the circumstances surrounding termination of the professional–client relationship, the client's personal history, the client's competence and mental status, the foreseeable likelihood of harm to the client or others, and any statements or actions by the therapist suggesting a plan to initiate a sexual relationship with the client after termination.

Gary Schoener, interviewed for an article in *Counseling Today* (Foster, 1996), discussed some useful questions that practitioners can ask themselves when they are considering a posttermination romantic relationship:

- What was the length and level of therapeutic involvement?
- How much transference, dependency, or power inequity remains after termination?

- Was there any deception or coercion, intentional or unintentional, by the therapist indicating that sex is generally acceptable after termination of therapy?
- Was there an actual termination? Was the decision to terminate a mutual one? Did the therapist end the professional relationship to make it possible to enter into a romantic or sexual relationship?
- Who initiated posttermination contact?
- What kind of consultation, if any, took place?

Despite the consistency shown by the professional *organizations*, there remains disagreement among *practitioners* about whether a sexual relationship initiated after termination is ever ethical (Moleski & Kiselica, 2005). Some practitioners maintain that "once a client, always a client." They contend that the transference elements of the therapeutic relationship persist forever; therefore, romantic relationships with former clients are always unethical. They also point out that a 2- or 5-year time limit is artificial and arbitrary and that it is nonsensical to assume that what was unethical for several years becomes ethical after a specific time period has elapsed. Furthermore, counselors often learn intimate details from clients during the counseling process, and that knowledge creates a power differential that has the potential to be abused in a future relationship (Moleski & Kiselica, 2005).

Whereas some take the position that sexual relationships with former clients are always unethical, others argue that a blanket prohibition of all sexual intimacies with former clients is too extreme. They contend that there is a real difference between an intense, long-term therapy relationship and a less intimate brief-term counseling relationship. What should be the appropriate response, for instance, by Ellen to Craig's invitation in the following scenario?

> Ellen served her counseling internship at her university's counseling center. One of her clients was Craig, a graduate student who was a businessman returning to college for his master's in business administration. Craig sought counseling because he was having second thoughts about committing himself to a lifelong career in the cutthroat competitive field he was in. During five counseling sessions with Ellen, he completed a series of inventories, weighed his values, and decided to switch majors. A little more than 2 years later, Craig and Ellen ran into each other at a social event. Craig asked her out on a date.

Assume that Ellen approaches you for consultation. She tells you that she does not want to be unethical, yet she also wants to accept Craig's offer for a date. Because Ellen had only five sessions with him, because the focus was on career counseling, and because the counseling took place more than 2 years ago, Ellen does not think that

accepting a date with Craig is unethical. However, she wants to get your opinion and wants to know if she is overlooking some important issues. What might you say to Ellen?

If Ellen consults with me, I will first ask her to state what she sees as the pros and cons of each decision. I will explore with her the reasons she is seeking consultation. Although she does not think accepting the date is unethical, she seems uncertain. Can she see potential problems in accepting? I will ask her if there is a pattern here. Has she dated other former clients? I will not flatly tell Ellen that accepting the date is either appropriate or inappropriate, although I will explore with her any possible consequences. I will ask her to consider carefully the factors listed by her professional association. My goals for the consultation are to have Ellen understand her reasons for choosing whatever course of action she may follow and be aware of and take responsibility for the possible consequences of her decision.

The counseling profession is clearer than it once was about sexual relationships with former clients. Still, whether sexual relationships with former clients are ever acceptable, even after more than 2 or 5 years, probably will be a subject of continuing discussion. On one hand, we need to remain aware of the harm that can result from sexual intimacies that occur after termination; of the aspects of the therapeutic process that continue after termination, including residual transference; and of the continuing power differential. On the other hand, it seems reasonable to consider the wide range of circumstances that could arise, especially the differences between long-term, intense, personal counseling relationships and brief, career-oriented, or other types of counseling.

Under the present codes, if a counselor does consider entering into a romantic relationship with a former client after 5 years have passed, some safeguards should be followed. These include consulting with a colleague, documenting carefully, and going for a therapy session conjointly with the former client to examine mutual transferences and expectations. As a general rule, Welfel (2013) states that counselors who consider entering into a sexual relationship with a former client, even many years after termination of the professional relationship, should be extraordinarily cautious about taking such a step. Careful consideration of the code and consultation with colleagues are critical. It is important to remain cognizant that because of the potential for exploitation in such a relationship, courts have found that posttermination relationships can violate the standard of care owed to clients (Shavit, 2005). Thus counselors are wise to refrain from posttermination sexual relationships except under the most unusual or exceptional circumstances.

Incidence of Sexual Misconduct

It is difficult to determine the actual incidence of sexual intimacies between therapists and clients—or between counselor educators and students or supervisors and supervisees. Phelan (2007) reviewed ethics complaints from

counseling, psychology, and social work organizations from 1996 through 2006 and found that dual relationships, particularly sexual dual relationships and sexual harassment, were the most common reasons for expulsion from professional organizations. Pope and Vasquez (2011) presented data indicating that sexual misconduct and unprofessional conduct are among the top five causes of disciplinary actions against psychologists.

Sexual dual relationships account for the largest share of formal complaints against psychologists, whether these complaints are filed with licensing boards, ethics committees, or civil courts. Kitson and Sperlinger (2007) compared attitudes of psychologists in the United Kingdom with attitudes of psychologists in the United States and found similarities. These researchers noted that the psychologists in both countries who were *least* likely to view dual relationships as appropriate were females, psychologists with the fewest years of experience, psychologists who experienced therapy as a client, and psychologists whose main theoretical orientation was psychodynamic. Kitson and Sperlinger found the most significant variable to be years of experience, potentially indicating that training has improved on this topic. In terms of the other variables, psychologists with a psychodynamic orientation may have an enhanced understanding of transference and countertransference and may be more likely to manage these issues effectively. Also, psychologists who have experienced personal therapy as a client may have more awareness of their vulnerabilities.

Hoffman (1995) reiterated that "the topic of sexual dual relationships encompasses complex, difficult, and controversial issues" (p. 21). Abbott (2003) found that constraints such as managed care and limited resources have shifted the therapeutic paradigm from psychoanalytic approaches and theorized that as mental health professionals have moved to more egalitarian relationships with clients, the nature of the relationship between therapists and clients has become more susceptible to intense emotional bonds. Furthermore, less emphasis placed in training on the psychoanalytic concepts of transference and countertransference has resulted in less understanding of these concepts. This lack of understanding could be contributing to inadvertent boundary violations. Strom-Gottfried (1999) concluded that violating professional boundaries may result from basic human vulnerability, erotic transference, and in some cases, misuse of power.

The Offending Therapist

Previous research has suggested that male therapists are far more likely to engage in sexual relationships with clients than are female therapists. Considering research on the characteristics of therapists who engage in sexual dual relationships, one profile that emerges is that of a middle-aged male therapist who is burned out, professionally isolated, and currently experiencing some personal distress or midlife crisis (S. Simon, 1987; Smith & Fitzpatrick, 1995). This therapist often begins by sharing his own personal life and problems with a younger female client. This profile shares many

of the characteristics of the impaired professional who has personal problems and attempts to meet his own needs through his clients.

Of course, not all therapists who engage in sexual dual relationships fit this profile, and other writers (e.g., Golden, in Schafer, 1990; Schoener & Gonsiorek, 1988) have suggested that there may be a wide range of types of professionals who become involved in sexual relationships with clients.

Legal Sanctions

Historically, the legal system and the professional community were slow to respond to clients' claims of sexual exploitation. When clients first began alleging that therapists were sexually exploiting them, many mental health professionals discounted the claims. In the 1960s and 1970s, some mental health professionals even defended sexual relationships with clients by alleging that they had therapeutic value (Welfel, 2013). In the landmark case of *Roy v. Hartogs* (1975), a court finally acknowledged that a psychiatrist caused harm by engaging in sexual intercourse with a client and that such action was not in accordance with acceptable professional procedures. The courage of victims in pursuing their legal claims and the persistence of scholars who demonstrated that sex with clients is harmful deserve credit for the resulting ban on sexual relationships with clients (Welfel, 2013).

Currently, the inappropriateness of engaging in sexual relationships with clients is universally recognized. Such behavior is considered unethical and illegal (G. Corey, Corey, Corey, & Callanan, 2015; Remley & Herlihy, 2014). Despite this consensus, one of the most common allegations in malpractice lawsuits against mental health professionals remains sexual misconduct (Pope & Vasquez, 2011).

In a malpractice case, the client has the burden of establishing by a preponderance of the evidence that the counselor had a duty to the client, the counselor breached the duty, and the client suffered harm. The client would have little difficulty establishing the duty element of malpractice because the very nature of a counseling relationship establishes a counselor's fiduciary duty to clients.

The client also would have to show that the counselor breached his or her duty to the client by not adhering to the standard of care in the community. Meeting the standard of care can be described as acting like other similarly trained counselors would act under the circumstances. The standard of care would be established by expert testimony and reference to codes of ethics. A court would apply this standard of care to the case at bar to determine whether a counselor breached his or her professional duty to the client. In the case of sexual contact with clients, courts have little trouble finding that a counselor breached his or her duty to the client.

Finally, the client has to establish that the client suffered harm because the counselor breached the duty to the client. Emotional harm is a compensable injury in a malpractice case against a mental health professional.

The emotional harm suffered by clients who had sexual relationships with their therapists is documented in the literature, which would support a client's claim that his or her mental health was negatively affected by a sexual dual relationship.

However, clients who bring suit are placed in a difficult position. They may be able to demonstrate that they personally have been harmed only by providing their own subsequent treating therapists with a release to testify regarding that harm, thus robbing them of the privacy of sensitive, confidential material they have revealed.

Courts now recognize that clients are vulnerable in a counseling relationship. Courts have also acknowledged that clients are likely to suffer serious emotional distress when they have engaged in a sexual relationship with their therapist (G. Corey et al., 2015). Austin, Moline, and Williams (1990) reviewed relevant court cases and concluded that few, if any, arguments in defense of therapists who have sex with clients are likely to succeed in court. In particular, courts have rejected claims that the client consented, determining that consent was not voluntary or informed because it was affected by transference. Most clients alleging sexual misconduct against their therapists have based their lawsuits on counselors' mishandling transference and countertransference reactions (Wheeler & Bertram, 2012). Courts have consistently held that counselors who mishandle transference and are involved in sexual relationships with their clients are negligent.

State legislatures are also addressing sexual dual relationships. Remley and Herlihy (2014) noted that some state legislatures have passed laws making sexual relationships with clients a case in negligence automatically. Thus the client would only have to prove he or she was physically, emotionally, and/or financially injured because of the therapist's behavior. Remley and Herlihy also reported on a Wisconsin statute that forbids mental health professionals from entering into out-of-court settlements if the terms of the settlement include not reporting the incident to the public.

Malpractice suits are tried in civil court. Increasingly, charges of sexual misconduct against mental health professionals can also be brought in criminal court. Criminal sanctions for sexual intimacy between a counselor and client vary by state. Kane (1995) found that sexual intimacies between counselors and clients are a violation of criminal law in California, Colorado, Connecticut, Florida, Georgia, Iowa, Maine, Michigan, Minnesota, New Mexico, North Dakota, South Dakota, and Wisconsin. Remley and Herlihy (2014) noted that some states take even tougher positions, such as allowing prosecutors to file injunctions against counselors, forcing them to discontinue their practice even before they are found guilty of engaging in sexual relations with clients, if it can be proven that the practitioner presents a risk to clients by continuing to practice.

In addition to having criminal charges or malpractice lawsuits filed against them, counselors engaged in sexual dual relationships with clients can be expelled from professional organizations and lose their insurance coverage. Furthermore, clients can file complaints against counselors with their state licensure boards. Licensure boards are responsible for enforcing codes of ethics. These boards can impose sanctions or even have a counselor's license to practice suspended or revoked if the counselor engages in inappropriate dual relationships. Many state licensure boards have revoked the licenses of mental health professionals who have had sex with clients (G. Corey et al., 2015).

Harm to Clients

As Bates and Brodsky (1989) have noted, problems in love relationships are frequently the impetus for clients to enter therapy. They contended that it is unforgivable for therapists to contaminate and deobjectify their role in helping to resolve these clients' problems. Therapy is not "a mating game, or a place for lovers to meet" (p. 133).

Kenneth S. Pope has produced an impressive body of research into sexual dual relationships. He provides a clear and comprehensive picture of the harm that may be done to clients by sexual relationships with their therapists. Clients may have reactions similar to those of victims of rape, battering, incest, child abuse, or posttraumatic stress. According to Pope (1988, 1994), 10 general aspects commonly associated with the syndrome are ambivalence, guilt, emptiness and isolation, identity/boundary/role confusion, sexual confusion, impaired ability to trust, emotional lability, suppressed rage, cognitive dysfunction, and increased suicide risk. It is worth examining each of these indicators in more depth.

- *Ambivalence.* Clients who are sexually involved with their therapist may experience a sense of deep ambivalence, fearing separation or alienation from the therapist yet longing desperately to escape from the therapist's power and influence. Loyalty to the therapist may prevent clients from acting to protect themselves (resisting sexual advances or reporting the abuse) for fear that their action could destroy the therapist's personal or professional life. This ambivalence and misplaced loyalty help to explain why the behavior can go unreported completely or for a number of years.
- *Guilt.* Clients may feel guilty, as though they are somehow to blame for what has happened. Their reactions may be similar to those of incest victims. They may have a sense of guilt that they did not do more to stop the sexual activity or that they enjoyed the relationship or that they did something to invite such a relationship with a person they deeply trusted.

- *Emptiness and isolation.* Sexual activity between a therapist and client can seriously erode the client's sense of self-worth. Clients may feel emotionally isolated, alone, and cut off from the world of "normal" human experience.
- *Identity/boundary/role confusion.* A phenomenon often involved in a patient–therapist sexual relationship is a reversal of roles. As the therapist becomes more self-disclosing, and as meeting the therapist's needs becomes more important in the relationship, the client becomes responsible for taking care of the therapist. Clients become confused, not knowing where safe and appropriate boundaries lie, and this adds to the erosion of their sense of identity and worth.
- *Sexual confusion.* Many clients seem to manifest a profound confusion about their sexuality. Lingering outcomes can take two forms: Some clients will be threatened by any sexual activity, and others may be trapped into compulsive or self-destructive sexual encounters.
- *Impaired ability to trust.* Because therapy involves such a high degree of trust, violations can have lifelong consequences. When therapists abuse this trust, they are taking advantage of their clients in the most fundamental way. This is perhaps the core issue in sexual violations, and the consequences can extend far beyond the therapeutic relationship in question. Client victims are likely to mistrust other helping professionals, particularly therapists, and the damage may reverberate outward to other, less intense relationships.
- *Emotional lability.* This can be a long-term consequence. Clients who have been sexually involved with a therapist often feel overwhelmed by their emotions, both during the relationship and afterward. Even with subsequent therapy, victims may re-experience traumatic emotions when they become involved with a new and appropriate sexual partner. Counselors who work with these victims need to keep these setbacks in perspective so that clients will not lose hope.
- *Suppressed rage.* Victims may feel a justifiable, tremendous anger at the offending therapist. But this rage may be blocked from awareness or expression by feelings of ambivalence and guilt and by manipulative behaviors of the therapist. Offending therapists may use threats and intimidation to prevent clients from reporting the behavior and can be adept at eliciting compliance, hero worship, and dependency. As is true of feelings of guilt, this anger needs to be identified, expressed, and worked through in later therapy with another therapist. If the anger is bottled up, it is likely to affect clients' relationships with significant others in their lives and with any other therapists from whom they might later seek treatment.
- *Cognitive dysfunction.* The trauma caused by sexual involvement with a therapist can be so severe that clients may experience cognitive dysfunction. Attention and concentration may be disrupted by flashbacks, nightmares, and intrusive thoughts.

- *Increased suicide risk.* Finally, suicide risk is increased for clients who feel hopelessly trapped in ambivalence, isolation, and confusion. These feelings, coupled with an impaired ability to trust, may prevent victims from reaching out for help.

It should be clearly understood that even if clients behave in seductive ways, it is always the *therapist's* responsibility to maintain a professional distance in the relationship. Therapists can help clients to understand such behavior on their part as a manifestation of transference. The therapist, not the client, has the responsibility to evaluate the therapeutic situation and to monitor the boundaries of the relationship. Therapists who have trouble keeping clear boundaries in the professional relationship are often guilty of poor judgment in other areas of their practice. Clearly, the effects on clients can be profound and violate one of our most fundamental moral principles: to do no harm.

A Contributor's Perspective

The following contributor's perspective by Beth Christensen illustrates in a powerful way the harm that can come from a therapist's exploitation and misuse of power. The case reinforces that it is always the therapist's responsibility to maintain safe and therapeutic boundaries.

Sexual Boundary Violations in Mental Health Counseling

Beth Christensen

In every class or presentation regarding boundary issues in counseling, when the subject turns to sexual relationships with clients, the admonition is as clear and succinct as one can imagine: "Don't!" Sexual boundary violations with current clients, or with partners or family members of clients, are absolutely and incontrovertibly forbidden. Counselors who violate this boundary with clients risk their careers, their licenses to practice, and their reputations. In some states, they may even risk criminal prosecution. Despite these serious risks to the counselor, sexual boundary violations continue to occur.

Sexual relationships with counselors and former counselors can cause serious harm to clients or former clients, harm that is manifested in virtually every area of their lives. There is some research on the effects of therapist–client sex in the professional literature, but there is not enough; the research that exists seldom goes deep into the subjective experience of the client/victim (Ben-Ari & Somer, 2004). Common consequences of therapist–client sex include low self-esteem; feelings of guilt, shame, and inadequacy; reluctance to speak to anyone about these experiences; and fear of entering into other therapeutic relationships. The harm imposed

on victims of sexual boundary violations often resembles that suffered by incest survivors, whether or not the client/victim has suffered incest in the past. More qualitative, subject-centered research into the dynamics of the harm caused by therapist sexual abuse, and the mechanisms by which healing from such abuse takes place, is needed.

I am a licensed professional counselor and a survivor of a sexual boundary violation by a therapist, in my case a psychiatrist. I welcome opportunities to speak from the perspectives of both a survivor and a professional, and for me, doing so is an act of rejecting the inappropriate shame that is such a common struggle for victims of sexual abuse. I fully embrace the feminist/humanist values that consider the voice of the client to be a valid source of knowledge, and I have focused my studies and dissertation research on the dynamics and the effects of sexual abuse. I think it is important to add a flesh-and-blood dimension to what can otherwise be a somewhat distanced, abstract subject. It can be very hard to hear the reality of what someone who usurps and violates the role of therapist can do to a vulnerable client.

My own experience may be more extreme than many; however, it is by no means particularly rare. I was 14 years old when I first saw a psychiatrist. I had suffered sexual abuse earlier in my childhood, and I was acting out my confusion and anger in very destructive and dangerous ways. I was desperate for someone to listen to me, really *hear* me, and to understand my anger and feelings of alienation. At first I was nervous about going to see a psychiatrist, but my doctor seemed to be the answer to my prayers. He acted very “cool” with me; I could tell him anything, and he would not respond in a judgmental or scolding way. In my angry adolescent mindset of “me against the world,” I thought I had finally found an adult who was on my side. I had also found a loving father figure who listened to my every word and who seemed to think everything I said was important. When he looked at me, I thought that finally there was someone who truly *saw* me. What he saw, however, was a perfect victim.

The sexual advances began slowly and in subtle ways, so that I often wasn’t sure if the hugs he gave me at the end of each session were for me or for him. As the hugs evolved into kisses and touching, he told me over and over that I was special, that I was mature for my age, that I was beautiful and brilliant, and that he loved me. Like any (by this time) 15-year-old, I longed to hear those words. When the sexual activity finally reached the level of intercourse, I didn’t have any capacity to say no; I never thought of that as an option. I had lost any sense of who I was except for what he told me. He said that I was sexy and irresistible, that he had to “have” me. He said I was no longer a child but a woman. He said that what we were doing was wrong, but he couldn’t resist me (which was his way of telling me that this was really *my* fault—a common tactic among child sexual abusers).

The things he told me, and the weekly sexual contact, only intensified the confusion, anger, and depression that had brought me to him in the

first place. I began living dual lives: the high school kid who was usually in trouble and, for one hour a week, the woman-child who was loved and desired. But this love was so confusing to me; I remember the sick feeling in my stomach when he would lock the double doors of his office (mine was always the last appointment of the day, after the secretary was gone), knowing that I would be his for the next hour. I remember taking the bus home in a daze after his appointments, as if I was moving through a fog. It didn't feel right, and a lot of times I wanted it to stop, but I didn't know how to make it stop. I also didn't know what I would do if he stopped "loving" me. He had placed himself in the center of my life, and I began to lose any sense of who I was beyond what he told me I was.

As my depression, anxiety, and destructive behavior worsened, he began to prescribe drugs for me. I also learned, as I had done as a child, to mentally escape the sexual episodes by dissociating myself from what was happening. I remember staring up into the lightbulb in the lamp until the light in my eyes made everything else disappear, until it was over. I stopped spending time with friends; I stopped doing homework or going to the movies; I stopped doing everything that connected me with the world of being a teenager.

As I became more detached from myself, increasingly numb and automaton-like when I was with him, I also became more enraged and self-destructive in other aspects in my life. Shortly after I turned 17, after at least 2 years of weekly rapes (as I have since learned to properly name them), this same doctor diagnosed me as having schizophrenia, and I began what would be 2 years of hospitalizations, at least 30 electroconvulsive therapy (ECT) treatments, and ever-increasing doses of mind-numbing psychotropic medications (this was in the 1970s, the days of Thorazine). I lost any conscious memory of the rapes; maybe that was because of the ECT or the medications, but more likely it was because I simply did not have the ego strength, maturity, and coping skills to acknowledge the horror of what he had done to me.

My diagnosis of schizophrenia was, by accident or design, a perfect cover for the psychiatrist; posttraumatic stress disorder and dissociative responses to trauma had not yet made their way into mainstream psychiatry (even now people with these types of trauma-based disorders are frequently misdiagnosed). The flashbacks and body memories, horrific episodes of re-experiencing what he and others had done to me, were interpreted as manifestations of my alleged psychosis. Furthermore, had I remembered the sexual abuse and tried to tell someone about it, he had made sure, by certifying me as insane, that I wouldn't be believed. He, at that point, fully owned me.

I did eventually go to another doctor, in another state, far away from my psychiatrist and other, earlier perpetrators, and I got better. The memory of the sexual abuse was stashed deep in some inaccessible place in my mind, and I began to assemble a life. In fact, it was a very successful life (at least on the surface), but I never, ever felt good enough, and I was

always followed by a cloud of fear that this horrible disease of schizophrenia would come back and rip my life to shreds. It was not until about 25 years after the abuse ended that I began to remember what he had done and how it had affected me. I realized that I had never had schizophrenia; all of the "craziness" I had exhibited was in response to sexual abuse, and the most devastating abuse had come from the one who had been paid to help me. I realized that all of the developmental milestones that should have been part of my young adulthood—graduating from high school, going to college, even experiencing my first love—had been stolen from me, and I would never get them back. The memories of the rapes, which I experienced in sickening visceral sensations and very real and immediate terror, overwhelmed me, and it has taken years of painful and difficult therapy to work through the rage, humiliation, shame, and grief over what he did to me and what he stole from me. Although I have come a very, very long way, the work continues, and I expect that there are some wounds that will never fully heal.

My case is probably not "typical," if there can be such a thing. But in my years of treatment, I have met and heard the stories of many women who were sexually abused by their therapists. Most of them were adults when the abuse happened. Most of them had suffered some amount of prior physical, emotional, or sexual abuse. Virtually all of the women expressed a feeling of "specialness" that had been communicated to them by the offending therapists, and they had a deep need in their lives to be seen as loveable and worthy of attention and affection. For some of them, the abuse recreated their earlier childhood sexual abuse, triggering a regressive response and a recreation of their feelings of helplessness, terror, and aloneness. All of them (including myself, despite my age at the time) believed, or had believed at the time, that they had consented. They believed they had had "affairs" with their therapists, and thus they shared equally in the blame. Ridding oneself of that shame and self-blaming is incredibly difficult. It can haunt survivors of therapist sexual abuse for a lifetime.

The imbalance of power between a therapist and a client makes true consent virtually impossible. When the client is a child, this inability to consent is obvious and, to most people, easy to recognize. When the client is a rebellious, angry adolescent, that inability might be called into question, as adolescent seductiveness and sexual promiscuity are sometimes a part of the acting-out behavior that brings them to treatment. When the client is an adult, many people would consider that she or he is fully capable of consent, so unless physical force is used, they would hesitate to call it rape.

In my experience, and my exposure to clients and peers who have been harmed by therapist sexual boundary violations, I have learned one central truth that I believe applies to all sexual encounters between a counselor or therapist and a client: *It is always the responsibility of the counselor/therapist to set and maintain appropriate boundaries. It is* never *the client's fault when inappropriate sexual contact takes place.* It is not uncommon for

the perpetrator to claim that the client was seductive and overwhelmed the perpetrator's self-control. Mental health care providers who have that little self-control are probably in the wrong profession. At the very least, it is imperative that all mental health professionals learn to recognize risk factors for sexual boundary violations; maintain a keen awareness of their own feelings, needs, and potential weaknesses; and take appropriate action to protect themselves and, especially, their clients.

Sexual Attraction Between Clients and Counselors

The existing codes are explicit with respect to sexual relationships with clients. However, they do not, and maybe they cannot, define some of the more subtle ways sexuality may be part of professional relationships. For example, sexual attractions between counselors and clients do occur, and it is not the attraction per se that is problematic. It is acting on the attraction that is inappropriate and becomes an ethical problem. It is not uncommon for clients to develop a sexual attraction to their counselor, and it may be inevitable that most counselors will at some time feel a sexual attraction to a client. Barbara, a counselor in private practice, related this anecdote:

> The client was my prototype of the physically attractive man. He was tall, lean but muscular, and very good looking. As counseling progressed, it became apparent that he was sensitive to others, had a solid sense of personal integrity, and had a great sense of humor—all qualities that I admire. I realized that I found him attractive but wasn't particularly concerned about it. After all, I had it in awareness and certainly didn't intend to act on my feelings. Then, during one session he began to relate a lengthy story, and my attention wandered. I drifted off into a sexual fantasy about him, I don't know for how long, probably only a few seconds. I snapped back to reality, and as I refocused on his words I realized he was now talking about sex. I nearly panicked: Had I somehow telegraphed my thoughts? I felt my face begin to redden, and compounded my discomfort by wondering if he saw me blushing and thought I was embarrassed about the subject of sex. With real effort I directed my concern away from myself and back to him and got through the rest of the session. I was so shaken by the incident that I immediately sought consultation.

Assume you are the person to whom Barbara turns for consultation. She wonders whether she should continue counseling this man or make a referral. Barbara tells you that she worries about the effect of her attraction on the counseling process. Yet she also wonders what she might tell him if she decided to suggest a referral to another professional. What might you suggest to Barbara? If you found yourself in a situation similar to hers, what course of action might you take?

Not only is it difficult to acknowledge sexual feelings toward a client, it is even more difficult to talk about these feelings with colleagues or in supervision (Pope, Sonne, & Holroyd, 1993). Despite the likelihood that sexual attraction is a common occurrence, there has been a lack of systematic research into the topic. Most practitioners reported that their graduate training and internships provided no coverage whatsoever about sexual attraction and characterize their graduate training on therapists' sexual feelings as poor or virtually nonexistent (Pope, Keith-Spiegel, & Tabachnick, 1986; Pope & Tabachnick, 1993; Pope & Vasquez, 2011).

Pope and colleagues (1993) identified the conditions necessary for learning how to recognize and deal with feelings of attraction to a client. They believe that exploration of sexual feelings about clients is best done with the help, support, and encouragement of others. They maintain that practica, internships, and peer supervision groups are ideal places to raise this topic and list some common reactions to sexual feelings in therapy, which include surprise and shock; guilt; anxiety about unresolved personal problems; fear of losing control; fear of being criticized; frustration at not being able to speak openly or at not being able to make sexual contact; anger at the client's sexuality; fear or discomfort at frustrating the client's demands; and confusion about tasks, boundaries, roles, and actions.

The tendency to treat sexual feelings as if they are taboo has made it difficult for therapists to recognize, acknowledge, and accept attractions to clients. According to Pope and Wedding (2014), national studies have indicated that simply experiencing sexual attraction to a client, without acting on it, makes the majority of therapists feel guilty and anxious. It is not surprising, then, that many therapists want to avoid acknowledging and dealing with sexual feelings. Although a majority of therapists reported feeling sexually attracted to some clients, and most reported discomfort with their feelings, the studies revealed that adequate training in this area is relatively rare.

In light of these findings, we recommend that counselor education programs place more emphasis on the issue of sexual attraction. Prospective counselors need to be reassured that their feelings are a common manifestation of countertransference, that these feelings are natural, and that with awareness and preparedness they can still counsel effectively with clients to whom they feel attracted. The importance of consultation should also be emphasized, in both preservice and in-service education, to help prevent sexual attraction from crossing the boundary into an inappropriate dual relationship.

Although it is a good practice to discuss concerns regarding sexual attraction with colleagues and supervisors, it is not wise and is inappropriate for counselors to share with a client their feelings of sexual attraction. In their research on counselors' perceptions of ethical behaviors, Neukrug and Milliken (2011) found that 89.7% of their sample of ACA members ($N = 535$) believed it to be unethical to inform clients about their attraction to them. Fisher (2004) discourages therapist self-disclosure of sexual feelings to clients and makes these suggestions regarding managing sexual feelings:

- Rather than making any explicit communication of sexual feelings for clients, therapists might consider acknowledging caring and warmth within the therapeutic relationship.
- Therapists do well to practice a risk management approach if they develop sexual feelings for a client. This would involve awareness of timing and the location of scheduled appointments, nonerotic touch, and general self-disclosure.
- Therapists should consider making use of supervision, consultation, and personal therapy throughout their careers, especially at those times when they are challenged.

Pope and Vasquez (2011) have summarized the issue of sexual attraction: "To feel attraction to a client is not unethical; to acknowledge and address the attraction promptly, carefully, and adequately is an important ethical responsibility" (p. 221). An excellent resource for further understanding is *Sexual Feelings in Psychotherapy: Explorations for Therapists and Therapists-in-Training* (Pope et al., 1993). Another valuable book is *Lying on the Couch: A Novel* (Yalom, 1997). Yalom's book presents a discourse on the slippery slope of sexual attraction between therapist and client.

A Contributor's Perspective

A Student's Struggles in Dealing With Sexual Attractions

Amanda Connell

My first introduction to the counseling field was in substance abuse counseling. This began during my community college years, and we were not taught about boundary issues such as how to deal with sexual attractions. As a result, I often felt unprepared when these situations arose. To compound the issue, as a result of my own history, boundaries were challenging for me. My personal therapy has been enormously helpful in this area as well as many others. Supervision and consulting with colleagues have also been very useful.

In my experience, it is pretty common for clients struggling with addiction to have poor boundaries. I learned early on that it was important for me to model clear boundaries with clients. Over time, I learned to not take client behaviors personally. What was important was to teach clients about appropriate behaviors and boundaries. I found it helpful to come from a place of compassion and understanding for my clients, with the awareness that many of them grew up in homes with exceedingly poor boundaries and oftentimes even abuse.

Early in my career as a substance abuse counselor, I encountered a client who presented me with numerous opportunities for growth in

learning about boundary issues. He exhibited poor impulse control and lacked appropriate social skills, in addition to his addiction. This became evident in the first group he attended, as he reached out and touched my hair, called all the females in the group "Babe" or "Honey" (myself included), and generally made sexualized comments to the women. Within a few weeks he had also discovered where I lived (I worked and lived in the same city) and proceeded to describe my house to me, which was unsettling given his stated attraction and demonstration of poor boundaries. One of the truly marvelous things about group counseling is that this can be the perfect environment to work on such matters. This is especially true when the group is as open, nurturing, and willing to work as was that particular group. Another key element is that this client recognized a need for change within a short time as we explored his loneliness and his inability to form meaningful intimate relationships. Over time, and with *a lot* of patience, diligence, and hard work on the part of all of us in the group, this client did make significant changes in his communication skills and boundaries. He also developed an increased respect for women. This was accomplished partly through clearly setting boundaries in the group by directly communicating what was and was not acceptable behavior and language. We took this further by working with the behaviors in the moment when they occurred, exploring his intentions and motivations, and then doing behavioral rehearsals so he could realistically practice the behaviors and language that would be both acceptable and welcomed by women and still convey his messages. We also helped him develop empathy and understanding for how his actions affected others, which was made possible by the other members' willingness to be vulnerable and direct about feeling offended, violated, or disrespected. It turned out that this client had a very tender heart and feelings of inferiority, but he had learned poor boundaries and offensive communication in his family of origin. By the time he graduated from our program, he was one of our most actively engaged members, helping other newer members with their boundaries and communication skills.

Another interesting case occurred during one of my groups with a client who regularly pushed boundaries and the patience of all the counselors in that community agency. He had a full array of disruptive behaviors. In one of my groups, he made remarks about my appearance and asked me out. As I consulted with colleagues and a supervisor, it became clear that although at first it appeared that he had some sort of attraction to me, his remarks were instead his way of attempting to gain power, control, and attention in the group. This insight enabled me to work more effectively with him, although his behaviors varied and continued to be demanding for all of us.

Another challenging situation with attraction occurred just after the conclusion of a group. A group member who had just graduated from our program stayed after the group while waiting for his ride home. I was doing paperwork and was distracted, and he was making small talk. He asked me if I was married, and because I was not really pay-

ing attention, I answered absent-mindedly that I was not married. That was a therapeutic error that I regretted when he proceeded to ask me out on a date. That got my attention, and I felt surprised and ended up handling it badly. I believe that he ended up leaving with hurt feelings, and I regret not having the knowledge and confidence to handle it better. Although I still find these types of situations to be uncomfortable, I do feel better equipped these days to work through sexual attractions with clients when they arise. A much more effective way to handle that situation would have been to have been paying attention first of all. Instead of just answering the question, I would have explored with him the reason for this question. When a client expresses attraction for his counselor, it is not about the counselor. I would be direct about the sexual attraction, normalize the feelings, and have a discussion about ethics and boundaries surrounding the topic.

There was another instance when I felt attraction for one of the clients. The thoughts and feelings came about suddenly and unexpectedly, and to be very honest I was mortified. In my inexperience, I did not know much, but I did definitely know that it was a cardinal error to have any romantic relationship with a client. The feelings scared me, but luckily I had my own therapy appointment just after work that day. It was a fascinating experience. I was very aware and open about my feelings, and I successfully processed them with my therapist. I was such a driven person at that time that I was living life out of balance and had shut down the dating aspect of my life. Remarkably, and much to my relief, when I saw that client the following week, the feelings of attraction were gone. I learned that those feelings were not about him but were instead a subconscious way of getting my attention to the need to live a more balanced existence.

Sexual attractions in the counseling field will occur from time to time because it is a normal part of being human. The manner in which they are dealt with makes a difference. I have found it helpful to engage in my own counseling and to actively obtain supervision and consultations with colleagues in these instances. I have also found it helpful to practice these situations in role plays in classes. Avoidance and denial of attractions are problematic in multiple ways. Awareness and a willingness to help clients process their feelings of attraction are critical components of effective therapy.

Consider, for a moment, how this subject applies to you.

- Have you had to struggle with the matter of sexual attraction in counseling relationships?
- If so, how did you deal with your feelings and the feelings of your clients?
- What would you do if you found yourself attracted to a client, or a client to you?
- What do you want to see included in training programs about issues of sexual attraction?

Prevention and Remediation

Sexual dual relationships are one of the most harmful types of unethical behavior. We have seen how destructive they can be for clients, counselors, and the profession as a whole. Because violations are common—and probably occur more frequently than we realize—we need to make concerted efforts toward awareness and prevention. Steps that can be taken include consumer education, support for the victims, improved counselor training, and monitoring professional practice.

Consumer Education

As professionals, we seem to be communicating well with one another regarding sexual dual relationships, as is evidenced by the large number of articles in our professional journals. However, it is equally important that we communicate clearly to consumers that they have the right to services that are free from sexual exploitation. Statements of client rights should include this information and be routinely distributed. An important step in prevention is to educate the public so that they have clear expectations about the counseling process and knowledge of the boundaries of the relationship.

Information about the ethical, administrative, and legal options available to clients who have had a sexual relationship with their counselors needs to be routinely shared with consumers. One excellent example of how this might be accomplished is the booklet titled *Professional Therapy Never Includes Sex* (California Department of Consumer Affairs, 2011), which was specifically designed to help victims of sexual exploitation by therapists. It describes warning signs of unprofessional behavior and presents the rights of clients. Another helpful resource for clients is a brochure titled *If Sex Enters Into the Psychotherapy Relationship* (American Psychological Association, 1987).

Support for Victims

Many counselors may feel unprepared to help clients, students, or others who have had sexual relationships with their therapists. It is important to remember that clients who have been sexually exploited tend to be exceptionally vulnerable to revictimization when counselors fail to recognize their clinical needs (Pope & Vasquez, 2011). An abused client can be empowered by taking action against the offending therapist. Despite the potential for healing, it is extremely difficult for an abused client to pursue a complaint. In addition to the emotional toll that the process takes, it requires perseverance and some sophistication about the ethical complaint process and the legal system.

Counselors who work with these clients need to have a high degree of preparedness. They may need to deal with their own feelings of discom-

fort at being involved in a complaint against a colleague. They need to know all the possible avenues of redress and the advantages and disadvantages of each, so that these can be communicated accurately to the client. Finally, counselors need to keep in mind that the decisions—whether to pursue a complaint, what avenue(s) to take—rest with the client.

Women report great reluctance to file complaints that could lead to disciplinary action against their therapists or trainers (Gottlieb, 1990; Hotelling, 1988; Riger, 1991). These women often have ambivalent feelings about reporting their therapists, but they also encounter institutional barriers within the profession that contribute to their feelings of intimidation and deter them from following through with the complaint process. Gottlieb (1990) suggested that there is a need for an organizational structure within the profession that will reach out to these women and assist them in the complaint process.

Counselor Education

Counselor education is discussed more fully in Chapter 5, but at this point we want to note some concerns specific to sexual dual relationships. We have the impression that, generally, counselor education programs are not giving much emphasis to the topic of sexual attractions between counselors and clients.

Pope and Vasquez (2011) reported that sexual attraction causes a great deal of discomfort among mental health practitioners, which may be the reason graduate programs and internships neglect educating students in how to identify and manage sexual attractions. Counselor education programs have a dual responsibility: to train prospective counselors and to protect the public whom they eventually will serve. Bartell and Rubin (1990) contend that education can play an important role in helping trainees first to recognize sexual attraction and then to take the necessary steps to avoid acting on the attraction. They suggest that the injunctions against sexual relationships be emphasized in training programs and be well publicized as a way to eliminate dangerous liaisons. Syme (2003) also recommended that graduate programs examine in detail the likelihood of erotic transference and countertransference in therapy and that they teach prospective therapists how to handle both of these phenomena.

On the matter of providing trainees with education on this subject, we think issues of attraction to clients ideally should be introduced in a beginning class in counseling, then dealt with in more depth in an ethics course, and further addressed in seminar sessions attached to students' fieldwork or internship experiences. Students are bound to encounter attractions as a part of their fieldwork, and instructors can encourage them to bring up these concerns for discussion. Individual supervision sessions provide an excellent venue for exploring these issues.

The findings from Harris and Harriger's (2009) study on sexual attraction in conjoint therapy suggested that new marriage and family

therapists are not confident about the course of action to take when faced with the issue of sexual attraction. These researchers claim that there is an urgent need to address this topic during a training program and to equip therapists-in-training with the skills to manage sexual attraction in a range of settings. We agree with Syme's (2003) observation that trainees may be very reluctant to publicly talk about feeling attracted to clients, but they will often do so privately in the safety of a supervision session. Some students may need to consider seeking therapy for themselves to explore their countertransferences and sexual attraction to clients.

Before attempting to educate others, instructors must gain their own clarity. Counselor educators who lack clarity will pass along their confusion to future generations of helping professionals, and counselor educators who behave in ethically questionable ways imply that those behaviors are acceptable. Counselor educators have a special obligation to be role models for what constitutes ethical behavior.

Thoreson, Shaughnessy, Heppner, and Cook (1993) suggest that issues of sexual contact between counselor educators and students and between supervisors and supervisees are more complex than issues of sex between client and therapist. Conflicting principles emerge, in that consenting adults have the right to establish consensual relationships, but because of the power differential involved, the notion of voluntary decision making is clouded with coercion. They recommended that education address the difficult issues of conflicting ethical principles, intimacy needs, the complexities of dual relationships, power inequities between "consenting adults," and gender-role stereotypes.

Monitoring Professional Practice

Professionals have been reluctant to report their colleagues who engage in sexual relationships with clients, students, or supervisees. Tabachnick, Keith-Spiegel, and Pope (1991) reported that 79% of psychology faculty who responded to their survey had ignored unethical behavior by colleagues. There may be a combination of explanations for this reluctance. In large measure, our sense of professional identity depends on the interpersonal bonds we form with our colleagues. We may fear being criticized or ostracized by colleagues for speaking out against "one of our own." The possibility of a defamation suit could also contribute to our hesitancy to take action. Many of us are reluctant to stand in judgment of others, particularly when we recognize our own fallibilities.

Consider what you might do in this situation: You become aware that a student intern in a counseling center has dated several of his clients. You and the student intern are in the same graduate program and are serving as interns in the same center. You approach him and inform him that you have heard from one of his former clients that they were involved in a sexual relationship. He tells you that he has no problem

with this because *both* he and his client are consenting adults, and that because he is not a licensed professional he is not bound by a set of ethics codes. In essence, he informs you that you are interfering in his personal business. Where would you go from here?

It is difficult for professionals to take action against colleagues. However, despite our reluctance, we clearly have an ethical responsibility to act when we have reason to believe that a colleague has engaged, or is engaging, in sex with clients. As Syme (2003) has so aptly stated, "If a therapist does not report suspected sexual abuse of a client by a fellow therapist, this is false loyalty and a derogation of their duty of care to the general public" (p. 16). Keep in mind that it is not our role to investigate, judge, or punish. These responsibilities belong to ethics committees, licensing boards, and the courts.

It may also help to remember that, sometimes, sexually exploitive behavior may be a symptom of impairment (Emerson & Markos, 1996). Characteristics of counselors who have become sexually involved with their clients parallel in many ways the characteristics of the impaired professional. Here are some of the similarities:

- Fragile self-esteem, possibly manifested in a narcissistic style
- Difficulty establishing intimacy in one's personal life
- Professional isolation
- A need to rescue clients
- A need for reassurance about one's attractiveness or potency
- Abuse of alcohol or other drugs

Because one of the most common mechanisms of impairment is denial, responsibility for confronting the problem is likely to fall on the professional colleagues of an impaired counselor. One ethical course of action is to confront the counselor and to do so with sensitivity, respect, and preparedness (Herlihy, 1996). If the counselor is receptive, options such as seeking help, suspending or limiting practice, working under supervision, or self-reporting can be explored. If the impaired counselor denies, rationalizes, or justifies his or her behavior, there may be no other option than to report him or her to a supervisor, an ethics committee, or a licensing board. Although some offending therapists who are experiencing burnout or impairment can be restored to healthy functioning, there may be others who should not be allowed to practice. The high rate of recidivism and the difficulty of ensuring that an offender has been "cured" are factors that support this stance. The first and highest obligation must be to protect clients from harm.

Conclusions

Having a sexual relationship with a client is one of the most serious of all ethical violations. All codes of ethics of the professional associations

prohibit sexual intimacies with current clients and with former clients until a specified amount of time has passed. The effects of sexual exploitation can be profound for the client, and the consequences can be severe for the counselor and for the profession. Sexual attraction to clients is not unethical, but acting on that attraction creates problems. This topic has not been fully addressed in counselor training programs and is deserving of more attention. The most productive future efforts will focus on prevention and remediation. The counseling profession needs to make a systematic effort to address sexual exploitation among its ranks and to educate clients about what they can rightfully expect from the professionals whose help they seek.

Chapter 3

The Client's Perspective

The beliefs and behaviors of mental health professionals regarding dual relationships have been extensively studied, but surprisingly little literature exists to describe the perspective or experiences of the client or consumer, particularly with respect to nonsexual dual relationships. We believe it is essential to consider the client's perspective. In this chapter we discuss the few studies that have been conducted on consumer beliefs and attitudes toward dual relationships and present some anecdotes in which clients speak in their own words about their experiences. We raise questions about the implications of our profession's focus on our own point of view. These questions frame our discussion:

- How do clients and potential clients view dual or multiple relationships?
- How do clients describe their experiences with dual relationships, both sexual and nonsexual?
- Do mental health professionals take a paternalistic approach to dealing with dual relationships? If so, how can we make clients active partners in the decision-making process?

Attitudes and Beliefs of Consumers

Walden (1996) studied the general public's knowledge of ethical counselor behavior, including nonsexual and sexual dual relationships. Her questionnaire was constructed from vignettes taken from the fifth edition of the *ACA Ethical Standards Casebook* (Herlihy & Corey, 1996). In one vignette participants were uncertain about the ethics of the behavior of a counselor who conducted business and social relationships with clients. Only 41.5%

"thought" or "strongly believed" this behavior was unethical. A second vignette described a sexual dual relationship between a counselor and a former client slightly more than a year after termination of the professional relationship. Again, respondents were uncertain, with 41.5% judging it unethical. Walden also found that there was no significant relationship between experience as a client in counseling and knowledge of counselor ethics. Walden's study was conducted nearly 20 years ago; contemporary consumers may be more educated about the professional ethics of therapists. Nonetheless, we believe her recommendations—that counselors work to educate the public about the ethical standards of our profession, and that we take steps to include the client's perspective in formulating and adjudicating our codes—remain valid and valuable today.

Clients' Experiences With Dual Relationships

Clients are often reluctant to take action against offending professionals (see Chapter 2). Even when boundary violations are sexual in nature, and when sexual advances are unwanted and sexual feelings are unreciprocated, reporting an offender can be a painful experience. Not all instances involve a client and a therapist. Other relationships involving a power differential, such as the relationship between student and professor, are potentially as harmful. Anonymous (1991) has written about her experiences with Professor X, a charismatic professor of counseling. Although Professor X singled out this student for special attention, praise, encouragement, and hugs, she trustingly failed to consider that he was "coming on to her" sexually until she learned that he had had affairs with other students. After much soul searching, she filed sexual harassment charges with the university and the ethics committees of professional associations. A lengthy process followed, filled with frustrations and disappointments for her, but in the end Professor X was found in violation and disciplined. Although this student successfully resisted the professor's attempted seduction and her complaints were successfully resolved, the experience was traumatic for her, as is evident in the following passages:

> I sat for hours, staring off into space, unable to focus. I saw Professor X as two images that refused to meld . . . his well-meaning, kind, and caring persona as opposed with a lustful and menacing one. I wondered if I had inadvertently given him some signal that I was approachable sexually. (p. 503)

> My anger grew as the week wore on. It emanated from deep within me—I felt consumed by it, and I felt that I would not be able to stop myself from expressing it the next time I saw Professor X. I avoided having any contact with him. (p. 505)

> I felt obsessed by the experience—it drew attention away from every area of my life. To keep myself going, I read about sexual harassment and about research regarding sexual intimacy between therapists and clients. . . . These activities helped me to combat the worst aspect of this problem—the loneliness. (p. 506)

It can be helpful for those who have been sexually exploited to read about experiences similar to their own. First-person accounts of sexual relationships with therapists include *Betrayal* (Freeman & Roy, 1976), *A Killing Cure* (Walker & Young, 1986), *Sex in the Therapy Hour: A Case of Professional Incest* (Bates & Brodsky, 1989), *Therapist* (Plaisel, 1985), and *You Must Be Dreaming* (Noel & Watterson, 1992).

Implications of a Paternalistic Stance

Counselors are likely to be uncomfortable with the notion of practicing paternalistic relationships with their clients. Nonetheless, the position taken by professionals with respect to dual relationships, as reflected in our codes of ethics and our professional literature, has tended to be paternalistic. Mental health professionals seem to have assumed that it is up to the *professional* to determine the boundaries of the relationship.

Mental health professionals should not abdicate their responsibility to maintain therapeutic boundaries in the interests of avoiding paternalism. However, when we assume that we are in a better position than clients to know how to protect them from harmful dual relationships (Nerison, 1992), we diminish the autonomy of our clients. To us, this underscores the importance of involving the client in ongoing discussions about relationship boundaries and potential dual relationship problems. It is important that we strive to balance our responsibilities for maintaining appropriate boundaries with our commitment to making our clients active partners in the therapeutic relationship. From our perspective, practitioners are challenged to include clients in ethical decision making that affects them, but practitioners have the ultimate responsibility for the outcomes. This process takes time, and it should include consultation, not only with colleagues but also with our clients.

Bringing the Client Into the Therapeutic Process as a Collaborator

A number of theories of counseling emphasize including the client in the therapeutic process as a collaborative partner. Some of the theories that emphasize the collaborative nature of the therapeutic endeavor include Adlerian therapy, cognitive behavior therapy, narrative therapy, solution-focused brief therapy, and feminist therapy. In social constructionism, a viewpoint that is becoming increasingly popular, the therapist disavows

the role of expert, preferring a more collaborative or consultative stance. Clients are viewed as experts about their own lives.

Adlerian therapists strive to establish an egalitarian therapeutic alliance with their clients. They consider an effective therapeutic relationship to be one between equals that is based on cooperation, mutual trust, respect, confidence, and alignment of goals. From the beginning of therapy, the relationship is collaborative, characterized by two persons working equally toward specific, agreed-upon goals.

Cognitive behavior therapy encourages clients to take an active role in the therapy process. Clients are expected to bring up topics to explore, identify the distortions in their thinking, summarize important points in the session, and collaboratively devise homework assignments that they agree to carry out. Cognitive therapists are continuously active and deliberately interactive with clients; they also strive to engage clients' active participation and collaboration throughout all phases of therapy.

Narrative therapists place great importance on the qualities a therapist brings to the therapy venture. Some of these attitudes include optimism and respect, curiosity and persistence, valuing the client's knowledge, and creating a special kind of relationship in which power is shared. Collaboration, compassion, reflection, and discovery characterize the therapeutic relationship. If counseling relationships are to be truly collaborative, therapists need to be aware of how power manifests itself in their professional practice. Therapists view clients as experts on their own lives.

Similarly, in solution-focused brief therapy, the emphasis is on creating collaborative therapeutic relationships. Although therapists have expertise in creating a context for change, clients are viewed as experts on their own lives, and they often have a good sense of what has or has not worked in the past, and what might work in the future. In short, collaborative and cooperative relationships tend to be more effective than hierarchical relationships in therapy.

Feminist therapists view the therapeutic relationship as being based on empowerment and egalitarianism. The very structure of the client–therapist relationship models how to identify and use power responsibly. Feminist therapists clearly state their values to reduce the chance of value imposition and to allow clients to choose whether to work with the therapist. Feminist therapists actively focus on the power clients have in the therapeutic relationship. They encourage clients to take charge of their lives and relationships by making choices that increase the possibility for experiencing mutuality in their relationships. Feminist therapists work to demystify the therapeutic relationship. They do this by sharing with the client their own perceptions about what is going on in the relationship, by making the client an active partner in determining any diagnosis, and by making use of appropriate self-disclosure.

A Contributor's Perspective

Susan L. Walden addresses the feminist model for ethical decision making and the importance of including the client's voice in ethical practice.

She describes important therapeutic benefits that can result from inclusion of the client in the ethical decision-making process. She also offers some strategies for accomplishing this goal at both the organizational and the individual levels.

Inclusion of the Client's Voice in Ethical Practice

Susan L. Walden

Numerous studies have investigated the knowledge, judgment, and experiences of counselors, psychologists, and social workers with respect to dual relationships and other ethical issues (Borys & Pope, 1989; Gibson & Pope, 1993; Gottlieb, Sell, & Schoenfeld, 1988). We have data reflecting practitioners' opinions on appropriate ethical actions as well as their self-reported practices when faced with ethical dilemmas. Although such studies certainly contribute greatly to our understanding, they tell only part of the story. The literature is scant concerning the other party in the counseling dyad—the client. Although it is true that both the professional and the field of counseling suffer when unethical practice occurs, in many cases the party who stands to incur the greatest harm is the client. Injury to clients resulting from dual relationships, especially sexual dual relationships, has been well investigated by Pope (1994) and others. The negative effects of dual relationships on clients have been documented.

Because of the potential for harm to clients, more attention must be given to understanding the client's perspective and to educating and empowering clients. Inclusion of the client in ethical considerations is not an attempt to "victim blame" or to shift the responsibility for ethical practice onto the client—the professional *always* bears the onus for maintaining professionalism and ethical practice—rather, inclusion of the client can be a strong asset to the counselor in resolving ethical dilemmas and can be a source of empowerment for the client.

Why has so little attention been accorded to the client's perspective? There are numerous possible responses to this question. First, perhaps tradition has dictated that we, as the professionals in counseling relationships, have the knowledge and training required to create and enforce the standards needed for best practice. Yet if we judge our clients as uninformed about the nature of counseling, we also deny them the potential for participation in the processes of understanding and resolving ethical dilemmas. Another potential explanation for the exclusion of the client perspective is the fear that telling a client too much about standards of practice might intimidate a client. For example, haven't we all occasionally worried that explaining all the limits of confidentiality to a client might frighten the client into silence?

A third possible hesitation in involving the client in ethical considerations is that an educated consumer base might result in an increase in ethics complaints. We are charged with the responsibility of monitoring ourselves and our profession. Most of the time we do a good job, as

evidenced by the fact that only a small percentage of mental health professionals are named in complaints to ethics boards. Perhaps we might do a better job, not by turning over the responsibility for monitoring practice to the consumers or by blaming the victims of unethical practice but by engaging the consumers of our services and empowering them in the process. We must remember that the client is the most important person in the counseling relationship.

Perhaps none of the aforementioned suggestions is accurate. It is possible that turning our focus to the client's perspective is simply a paradigm shift of sorts. We have espoused a somewhat paternalistic model of practice in the profession of counseling and in the creation and enforcement of ethical standards. We, as the professionals, create a set of standards that we believe will protect the client's welfare and best interests, yet we do this without the input or presence of the consumers of our services. I suggest that involving the client represents a natural step from a therapeutic benefits stance as well as a genuine move toward the aspirational level of ethical practice.

Therapeutic Benefits

Potential therapeutic benefits may be derived from the inclusion of the consumer perspective in ethics. First, when we make decisions concerning a client *for* the client rather than *with* the client, we rob the client of power in the counseling relationship. Conversely, when we create collaboration between counselor and client, the client is empowered. The concept of collaboration emphasizes the importance and essential nature of both parties in the relationship. Although counselor and client each bring different contributions to the collaboration—the counselor's training and professional experience and the client's strengths, hard work, and life experiences—both contributions are essential for the success of the counseling endeavor.

Client empowerment through inclusion in ethical considerations is a good fit with current thinking in the mental health professions. Newer therapies, particularly social constructivism and solution-focused brief therapies, emphasize the collaboration between counselor and client. The aim is to work toward goals determined by the client, drawing on the successes and strengths of the client. Why not extend this way of thinking into the arena of ethics? Bringing the client into an ongoing dialogue regarding a potential dual relationship or other ethical concern should be a continuous process if we are truly to work within the client's frame of reference, respecting the client's views. We cannot pretend to understand fully the client's view of a situation or gauge the potential ramifications of certain decisions for the life and well-being of the client accurately. What we may hope to communicate is a genuine regard for the impact of a situation on the client and respect for the client's welfare in working to find the solution that best protects and respects the client. By soliciting the client's perspective, we may ultimately achieve better counseling results and the best resolution for any ethical questions that arise.

Let's examine the case of a client who presents with complaints of social isolation. She and the counselor work for several sessions reframing her sense of isolation, highlighting her strengths, and building strategies for connecting with others in social situations. When she invites the counselor to accompany her to a party, the counselor is concerned about the dual relationship implications but fears hurting the client. Rather than just turning down the client's offer or making the excuse of previous plans, the counselor might engage the client in a discussion of the ramifications of such a venture, eliciting the client's thoughts and feelings about potential situations that might occur, including the impact on the client and the counseling relationship. Some clients may be unable to see the potential risks involved in the situation, and in those cases the ultimate decision rests with the counselor. However, in many cases, counselor and client working together may arrive at a solution that enables the counselor to preserve the counseling relationship while helping the client feel a part of the decision-making process.

A second therapeutic benefit derived from the inclusion of the client perspective may be more culturally appropriate practice. The counseling profession is growing in its understanding of the demands of counseling in a culturally pluralistic society. Our codes of ethics may reflect primarily Western values and certain cultural biases, but they do not have to be applied in a culturally encapsulated manner. The *ACA Code of Ethics* (American Counseling Association [ACA], 2014) addresses culturally appropriate practice, for example, in the provisions made for bartering and the giving of gifts, which have important cultural implications for some clients. When the counselor has strict beliefs or policies regarding accepting gifts, misunderstandings may occur. However, if counselors are willing to understand the client's perspective and share their own perspective, a solution may be reached by working together. Without such an exchange of views, the client may be offended by the counselor's behavior. With an exchange, client empowerment and the selection of a solution more in keeping with the client's cultural values are possible. Garcia, Cartwright, Winston, and Borzuchowska (2003) proposed integrating multicultural theory and competencies into the process of ethical decision making. They emphasized the significance of a client's and counselor's worldviews in influencing the resolution of ethical issues in counseling. We can be culturally inclusive in the application of ethical standards, and the inclusion of the client perspective may be an important step toward this goal.

Aspirational Level of Ethical Practice

Not only are there potential therapeutic benefits to be gained by including the client's perspective in ethics, but such practices also speak to the attainment of the aspirational level of ethical practice. At the aspirational level, the practitioner is concerned with the spirit of the code and the moral

principles on which the code rests (Remley & Herlihy, 2014). Functioning at the aspirational level of ethics means that the counselor's concern is for the welfare of the client. The inclusion of the client's voice in ethical matters speaks to this higher level of ethical functioning.

When a practitioner has decisions to make or ethical dilemmas to resolve, certainly the responsible professional consults the appropriate standards and is mindful of the impact of potential decisions on the welfare of the client. However, even the most well-meaning and skilled practitioner cannot fully understand the client's perspective or investment in the situation without the input of that client. Although we may see a situation as being relatively low risk for a client, the client may view the situation differently. It is questionable whether it is truly possible to attain the aspirational level of ethical functioning *without* including the client in the decision-making process. In order fully to prize and value a client and represent what is in the client's best interests, should we not involve the client in the process? Only by asking the client can we really know what a situation looks like through the client's eyes.

The potential benefits of including the client perspective in ethics issues are many. Numerous therapeutic advantages may be gained, and a practitioner has moved closer to the aspirational level of ethical practice. Ultimately, such genuine regard for the client's welfare may bring about benefits for the counselor, for the profession, and, most important, for the client.

Operationalized Client Inclusion

With the rationale in place for the inclusion of the client perspective in ethics, the question becomes how to put this process into practice. Infusion of the client perspective begins on two major levels: the organizational level and the individual level. At the organizational level, professional counseling organizations can utilize several strategies to promote the client perspective. First, we must continue and strengthen our efforts at educating members of the public in general and our clients in particular regarding ethical practice. Frequent reference has been made in the literature to the benefits of educating consumers of counseling services regarding ethical considerations. In addition, most state licensure boards and other ethics bodies have begun to require that practitioners provide professional disclosure statements and utilize informed consent procedures. These developments are much needed and provide a useful source of information for our clients.

A second strategy for client inclusion at the organizational level involves client participation in the creation and adjudication of ethics codes. Rather than the paternalistic model currently in place in which we (the professionals) create and adjudicate our codes of ethics without the voice of the consumers, we might include representation by members of the general public. Although the American Psychological Association's

Ethics Committee has included a nonpsychologist member since 1987, ACA has not included a member of the general public on its ethics committee. Given the vast human resources we have in ACA, it does seem that the logistical aspects of appointing a consumer member to the ACA Ethics Committee could be managed if the membership and leadership of the organization supported such a move. By adding the voice and unique perspective offered by a consumer, we might be better able to formulate standards that protect our clients, better understand the implications of ethical and unethical practice for the client, and also indicate to the public that we as a profession are interested in protecting the rights and welfare of those who utilize our services.

A third component of client inclusion at the organizational level is to develop ethical decision-making models that include the client's voice in the resolution of ethical dilemmas. Consultation with the client can be included at every stage of the decision-making process. An ethical decision-making model described in *A Practitioner's Guide to Ethical Decision Making* (Forester-Miller & Davis, 1995) is a useful tool for the resolution of ethical dilemmas; however, the model does not call for consultation with the client as a part of the decision-making process. Hillerbrand and Stone (1986) suggest that the client is an integral part of the "ethical community of the counseling relationship," capable of participating in determining appropriate actions in ethical dilemmas. The feminist model for ethical decision making (Hill, Glaser, & Harden, 1995) calls for consultation with the client at every stage of the decision-making process. More recent models for decision making have been proposed, including the social constructivism model (Cottone, 2001), which is based on the systemic-relational service models, and the collaborative model (Davis, 1997), which values inclusion and multiple perspectives and goals. Both models acknowledge that multiple parties are affected by practice and ethical decision making and emphasize a collaborative approach to the resolution of issues.

The transcultural integrative model (Garcia et al., 2003) rests on the essential influence of both client and counselor cultural perspectives. Herlihy and Watson (2006) proposed a paradigm for ethical decision making based on ethics, cultural identity development, and collaboration between counselor and client. This approach emphasizes the essential components of promoting social justice based on the client's worldview, the understanding by the counselor of the influence of culture on the counseling process, and the value of the client's participation in all aspects of the counseling relationship. These models all represent significant steps away from the individual perspective and influence common in earlier models.

Most ethical decision-making models share many common steps or procedures in the resolution process. The feminist model (Hill et al., 1995), which emphasizes the importance of including the client throughout the process, applies the following steps:

1. Recognize a problem
2. Define the problem (collaboration with the client is essential at this stage)
3. Develop solutions (with client)
4. Choose a solution
5. Review the process
6. Implement the solution and evaluate the result (with client)
7. Continued reflection

In the fifth step, which calls for consideration of the consequences of all options, readers are reminded to ponder the implications of each course of action for the client. The authors of the feminist model specifically state that consultation with the client "as fully as is possible and appropriate" is an essential step in ethical decision making (p. 27). The inclusion of the client in the decision-making process is a stated component of several steps of the feminist model. Ethical decision making from a feminist therapy perspective calls for involving the client at every stage of the therapeutic process, which is based on the feminist principle that power should be equalized in the therapeutic relationship (Brown, 2010). The decision-making model presented in the final chapter of this book provides an excellent model for the resolution of ethical dilemmas involving dual relationships, and the model includes consultation with the client.

A guide for ethical decision making published by the ACA Ethics Committee that reflects current thinking in the resolution of ethical dilemmas, with an emphasis on the inclusion of the client's voice, would be welcomed at this juncture. Such a step at the organizational level certainly would both instruct practitioners about the importance of including the client perspective and give them concrete strategies to use. The support of such practices from the professional organization would surely impress upon the membership the importance of the client perspective and should ultimately lead to fewer misunderstandings and healthier relationships between counselors and their clients.

At the individual level, numerous strategies may be employed to involve the client in ethical matters. Informed consent is the process that most commonly includes the client in discussions of ethics, and practitioners can discuss potential dual relationship and other boundary issues at the outset. A good practitioner will revisit areas of informed consent periodically and especially as ethical concerns arise. Because informed consent by nature necessarily involves the client, perhaps reframing it as a process rather than an event will help counselors to be more inclusive of the client as the counseling relationship progresses. Another strategy for the individual practitioner involves utilizing a professional decision-making model when ethical dilemmas arise. This model should include consultation with the client at any and all possible stages during the process.

One final suggestion for infusing the client perspective involves the counselor educator. As counselor educators, we teach ethical principles to our students through our courses and through our deeds. If we teach students the process of informed consent and how to include the client in ethical decision making, we are equipping them from the beginning with a client-oriented philosophy and strategies. In addition, we can model these practices through our dealings with them in the teacher–student relationship.

Summary

The inclusion of the client's voice in ethical matters may not be appropriate in all situations, and some clients may not be able to participate fully or objectively in the resolution of ethical dilemmas. Nonetheless, the client perspective is an essential component of sound ethical practice. There are therapeutic benefits to be gained in terms of client empowerment and culturally appropriate practice. We strive toward the aspirational level of ethical practice when we value the client's perspective. There are few risks involved in bringing the client into ethical matters, and the benefits are many, not only for the professionals and for the profession but also, and primarily, for the client. When we value our clients, we do all that is possible to understand the world through their eyes. When we listen to our clients, we teach them that their voice is important and is heard. When we include our clients in the process of ethical decision making, we empower them. When we include our client's perspective, we decrease the likelihood of harm to clients and increase the opportunities for positive results in counseling.

A Contributor's Perspective

Ed Neukrug describes the postmodern and social constructionist perspective, in which the therapist disavows the role of expert, preferring a more collaborative or consultative stance. Certainly the therapist has expertise in bringing knowledge and skills to a client's situation, but the client is viewed as the expert about his or her own life. The client is invited to become an active agent in the therapeutic process, and the voice of the client is given priority.

From the Client's Voice: A Postmodern, Social Constructionist Perspective on Ethical Decision Making

Ed Neukrug

Counselor as Expert in Ethical Decision Making

The traditional manner of ethical decision making views the counselor as an expert who must, under the duress of a tough ethical dilemma, decide

the "correct" path of action for both the counselor and the client (Geraghty, 2012). This notion of therapist as expert and final authority dates back to the beginning of counseling and psychotherapy.

The philosophical influences that led to the idea of the therapist as final authority and expert included the rise of structuralism and modernism during the late 19th and the 20th centuries (Hansen, 2010; Payne, 2006; Russell & Carey, 2004). These philosophies suggested that counselors, with their expert knowledge, techniques, and skills, could help clients uncover their problems and then help them find solutions. Aligning with the structural tradition, problems were seen as residing within clients, and if one could delve deep enough, analyze properly, or scientifically understand the person, problems could be revealed and understood and solutions found (Besley & Edwards, 2005).

Most major theories of counseling and psychotherapy have embraced the basic assumptions of modernism and structuralism (Hansen, 2006; Xu, 2010). For instance, psychodynamic therapists work with the unconscious in a manner that suggests an inherent structure drives behavior and only the expert analyst can help the "patient" understand it and make it conscious (Neukrug, 2011). Although behaviorists have a very different view that assumes individuals are wired to respond to environmental stimuli that shape their behavior, like the analyst, they too believe it is only through the knowledge base of the expert (in this case, the behavior therapist) that a person can come to understand his or her conditioning and begin a reconditioning process. Cognitive therapy brought forth the notion of cognitive "structures" (e.g., schemas and core beliefs) being responsible for a person's well-being or lack thereof. And, once again, these theorists suggested that the expert (the cognitive therapist!) could help the client understand and change these structures. Finally, even existential humanists suggested there was an inherent structure, "the self," that one must actualize in an effort to become congruent or real. In this case, it is the existential humanistic therapist that has attained the expert skills needed to provide an environment conducive to a search for the self (e.g., demonstrating empathy, unconditional positive regard, and genuineness).

Diagnosis reinforces the counselor's role as expert and helps counselors objectify clients as it enables professionals to maintain a safe distance between themselves and their clients (Hansen, 2003). Using a diagnostic nomenclature supports the view that the actions of our clients are the result of their inherent personality structures. Perhaps they "have" a personality disorder, are major depressives, or have an anxiety disorder. In fact, we have so convinced ourselves that problems reside within our clients that we have created a book, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM;* American Psychiatric Association, 2013a), that reinforces this notion. Unfortunately, the *DSM*, at best, is a dictionary that offers a consensus of what individuals believe are diagnostic categories (Insel, 2013), and at worst, is a tool that ensures the continuation of the existing power structure that therapists hold over their clients (McLaughlin, 2006).

Because theory and diagnostic manuals have reinforced the notion of the counselor as an objectivist, somewhat removed expert, when it comes to ethical concerns, counselors and therapists who embrace modernism usually try to fix the problem—and our ethics codes reinforce that notion. For instance, counselors are encouraged to take action and "protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed" (ACA, 2014, Standard B.2.a.). Or consider the flirtatious client. Because our ethics codes suggest that we have clear and appropriate boundaries with our clients, counselors characteristically move to set strong boundaries with flirtatious clients, assert their power as experts who need to control their client's seductiveness, and often diagnose the client in a manner that places a safe amount of distance between them and their clients (e.g., the "histrionic" or "borderline" client).

But what if our modus operandi—our way of being as counselors and therapists—is largely a reflection of a structuralist and modernist worldview that has encouraged the belief that problems reside within the person and fostered the notion that counselors should act as the expert in a somewhat removed fashion? And what if these beliefs are just one manner of working with clients? Might there be a different way?

Counselor as Collaborator in Ethical Decision Making: A New View

In more recent years, with the emergence of the philosophies of poststructuralism, postmodernism, and social constructionism, new therapeutic approaches have arisen that challenge the assumptions of structuralism and modernism and approach the helping relationship in new and profound ways that question the very core of the counselor as expert (Gergen, 2009; Guterman, 2013; Hansen, 2010; Payne, 2006; Winslade, Crocket, & Monk, 1997). These approaches suggest that how language is shared between and among people is a factor in the creation of reality. They go on to propose that the use of language by those in power can result in the oppression of others and the belief that others are the problem (e.g., parents holding power over children, dominant cultures holding power over nondominant ones, and, yes, even therapists holding power over their clients). Narrative therapy and solution-focused counseling propose that "problems" do not reside within the person but are a result of the milieu of conversations in which the person participated within his or her lifetime. Understanding the client from this perspective depathologizes the client, and the helping relationship is seen as a new and humanizing conversation that could potentially open up innovative views of the world (Dybicz, 2012). Here the therapist is no longer seen as the distant expert who is judging the client through a particular frame of reference. Instead, this counselor sees the counselor–client relationship in a collaborative manner,

one in which the counselor and the client share their thoughts on the ethical decision-making process.

In considering ethical dilemmas, a postmodern, social constructionist approach suggests that clients have constructed their realities based on their discourses with others throughout their lives (Geraghty, 2012). Ethical dilemmas "brought to the counselor" are partly a function of these discourses and will continue to form as the discourse unravels with the counselor or therapist. Therefore, decisions about dilemmas will be made through ongoing discourse. The role ethics codes play in the ethical decision-making process is seen as somewhat of a mixed bag (Guterman & Rudes, 2008). Ethics codes can be seen as being a result of modernist and structuralist thinking developed to maintain the counselor's power base in the relationship. However, from a social constructionist perspective, ethics codes are seen to have evolved over time as the conversation has changed about what is professionally right and wrong. Guterman and Rudes proposed that codes can be used from a postmodern, social constructionist perspective to help "inform the positions that counselors take" (p. 140), as opposed to the modernist approach, which fosters the notion that counselors should use ethics codes as a set of rules to which they must adhere.

Applying the New View of Ethical Decision Making

Given the above understanding of how a counselor might work from a postmodern, social constructionist perspective when faced with ethical dilemmas, let's contrast the modernist counselor with the postmodern, social constructionist counselor when dealing with a specific ethical dilemma.

> Reanne is a 59-year-old mother of three adult children who has survived her only husband. She has just been diagnosed with terminal cancer. You have recently started seeing her as a client, and in the last session, she informs you of her diagnosis. She tells you that the doctors won't give "timelines" but she is confident she has less than a year to live, perhaps only a few months. There is no treatment, she tells you. She then informs you that she has already devised a plan on how to kill herself, and she hopes to do so within the next month. She asks you not to interfere because she does not wish to live a long, drawn out, painful last few months of her life. What do you do?

When working with Reanne, the modernist counselor is hopeful that somehow his or her theory will set a direction for the counseling sessions. Perhaps this counselor will get advice on what to do next from a supervisor, and he or she is likely to refer to the ethics code and seek direction from it. Examining the *Code*, the counselor might see that the ACA (2014) suggests that counseling for end-of-life decisions is acceptable, so the counselor might consider whether this situation fits under that heading. Certainly the ethics code will also suggest that one must ensure that

a client not harm him- or herself, and many counselors will want to act in some fashion to ensure that Reanne does not commit suicide. On the other hand, some might wonder what "harm" means. Does it include ending one's life if one is in excruciating pain? In addition, some may seek "advice" from a variety of ethical decision-making models (Neukrug, 2012).

These are tough ethical decisions with which counselors might struggle, and all of the responses described are admirable and show an earnest desire to help the client. However, although these responses can be justified by today's "standards" in counseling, they are all based on a modernist model of counselor as expert in which the counselor tries to somehow "fix" the problem from a somewhat aloof and objective perspective. What they do not do is include the client in the decision-making process.

In contrast, the postmodern, social constructionist counselor realizes that any theory is just one take on reality, as are the ethics codes, models of ethical decision making, and even the supervisor's response to a dilemma. This counselor does not automatically run to theory, codes, ethical decision-making models, or to his or her supervisor but brings all of these points of view into the conversation with the client. The postmodern, social constructionist counselor offers such knowledge within the context of a shared, collaborative conversation, not as "I as expert." In this context, the postmodern, social constructionist counselor might do the following:

1. Listen, use empathy, and try to understand the client's current life story.
2. Be humble and respectful as the counselor realizes that the client's decision is based on a lifelong series of discourses about family, illness, and suicide.
3. Asks questions to understand the client's developed reality and how she came to make the choices she is currently making.
4. Actively attempt to not express a particular point of view that will make the client feel bad about herself, pathologize her, or push her toward taking a particular action.
5. Gently ask the client if there are other points of view that she has considered.
6. Gently ask the client if she would like to include others in her decision-making process—others who are important to her in the development of her life story.
7. Share with her the ethics code, legal requirements, personal counseling model, and other relevant thoughts and concerns the counselor might have about her situation, and ask the client what she thinks of them and how they might influence her decision-making process, if at all.
8. Consider whether to invite the supervisor to engage in conversation with the therapist and client. If so, ask the client how she might feel about the addition of the supervisor.
9. Engage in conversation with the client and others who might be jointly invited.

10. Listen to what the client ultimately wants, share thoughts about what the client says, and make a personal decision concerning whether the therapist can live with whatever her decision is. If not, go back to conversation with the client.

Final Thoughts

The above example contrasts the counselor who holds a modernist perspective with one who has a postmodern, social constructionist understanding of the world. Whereas the modernist counselor seeks advice and answers through outside experts and sources so that he or she can "act," the postmodern, social constructionist counselor includes outside experts and sources as part of the conversation that will happen between the counselor and the client. Whereas the modernist counselor wants to actively find something to do to the client, the postmodern, social constructionist counselor wants to understand the client's current reality and how she came to it. Whereas the modernist counselor is likely to act to prevent the client from doing something harmful to herself, the postmodern, social constructionist counselor wants to explore all of the client's narratives to ensure that the client is making the right choice for herself. And finally, whereas the modernist counselor is concerned about adhering to the ethics code and the law, the postmodern, social constructionist counselor is concerned about bringing the ethics code and the law into the conversation and the decision-making process with the client.

When faced with thorny ethical decisions, counselors are ethically and legally bound to make decisions within the context of their ethics codes and the law. However, one can see how a postmodern, social constructionist approach can, on rare occasions, lead a counselor to a conversation with a client that considers actions that would violate the counselor's ethics code and even the law. Ultimately, the counselor must make a decision that serves the client *and* the counselor best. Knowing the limits of the codes, the reach of the law, and the result of violating one's code and the law, the counselor must think long and hard when faced with a difficult ethical dilemma that could result in a decision that violates the law or the counselor's own ethics code. At that point, the counselor must decide on what action to take to preserve her or his own life story, and the counselor may want to share those concerns with the client. Then the conversation with the client can move forward, and this new conversation may become another decision point for the client. As the client hears the counselor's dilemma, the client may change his or her understanding of what to do. If not, the counselor must decide what he or she wants to do.

Conclusions

This chapter on the client's perspective concludes our introduction to dual or multiple relationships. In Chapter 1 we provided a foundation by de-

fining dual relationships and discussing relationship boundary issues. We looked at risks and the potential for harm and offered some safeguards to minimize risk. In Chapter 2 we explored sexual dual relationship issues. In this chapter we focused on the client's perspective and suggested a rationale and strategies for including clients in ethical decision making. In the next four chapters, we turn to multicultural and social justice perspectives on boundaries and highlight boundary issues in counselor education, supervision and consultation, and the education and training of group counselors.

Chapter 4

Multicultural and Social Justice Perspectives on Boundaries

In this chapter, we address boundary considerations from multicultural and social justice perspectives. Sue and Sue (2013) describe social justice counseling as an active philosophy and approach aimed at producing conditions that allow for equal access and opportunity. "Social justice counseling with marginalized groups in our society is most enhanced (a) when mental health professionals can understand how individual and systemic worldviews shape clinical practice and (b) when they are equipped with organizational and system knowledge, expertise, and skills" (pp. 108–109). From this perspective, the helper's role is broadened beyond that of a traditional mental health provider. Traditional models and techniques need to be aligned to best suit the diverse worldviews of clients. The strong individualistic bias of contemporary theories and the lack of emphasis on broader social contexts, such as families, groups, and communities, may not provide a wide range of clients with what they most need. In many cultures, collectivism is valued and identity is not viewed as being separate from the group orientation. Counselors with a multicultural and social justice orientation will be challenged to redefine the boundaries of their professional roles and to modify the way they practice with clients. Becoming a multiculturally competent counselor entails a shift in thinking and demands a different way of acting and practicing that several guest contributors describe in this chapter.

A few of the questions we explore in this chapter are:

- Is it ethical to barter with clients for goods or services?
- Under what circumstances, if ever, should a counselor accept a gift from a client?

- What are the appropriate limits of self-disclosure, and how could overextending these limits create a dual relationship problem?
- What alternative roles do counselors need to assume to effectively serve a culturally and ethnically diverse population?
- How does the social justice orientation differ from traditional approaches to counseling?

The choices practitioners make regarding these issues are likely to either confound or clarify their attempts to practice aspirational ethics within an increasingly diverse world.

A basic theme that runs throughout this chapter is that the cultural context needs to be considered when determining appropriate therapeutic boundaries with clients. Eight guest contributors add their voices to this chapter:

- Fred Bemak and Rita Chi-Ying Chung present multicultural and social justice perspectives on boundaries with culturally diverse clients.
- Derald Wing Sue and Christina Capodilupo explore the cultural context of working with boundaries and present an Asian perspective on reconsidering some counseling practices.
- Thomas A. Parham and Leon D. Caldwell provide an African-centered perspective in rethinking the definition of appropriate boundaries.
- Raul Machuca describes boundary concerns with Latino clients.
- Mevlida Turkes-Habibovic explores boundaries in counseling Muslim clients.

Bartering for Goods or Services

In the most recent revisions of the ethics codes of mental health professionals, the standards pertaining to bartering have been refined, and bartering is more generally discouraged. Although bartering is not often practiced and is not encouraged, the codes of various professions do recognize that there are circumstances in which bartering may be acceptable and that it is important to take into consideration cultural factors and community standards.

> Counselors may barter only if the bartering does not result in exploitation or harm, if the client requests it, and if such arrangements are an accepted practice among professionals in the community. Counselors consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract. (American Counseling Association [ACA], 2014, Standard A.10.e.)

> Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if: (a) the supervisee or client requests it, (b) the relationship is not exploitative, (c) the professional relationship is not distorted, and (d) a clear written contract is established. (American Association for Marriage and Family Therapy [AAMFT], 2012, 7.5.)

> Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (American Psychological Association [APA], 2010, 6.05.)

> Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship. (National Association of Social Workers [NASW], 2008, 1.13.b.)

Although the ethics codes do not prohibit bartering, they do offer cautions regarding the practice. There are potential problems with bartering, even though the practice may be motivated by an altruistic concern for the welfare of clients with limited financial resources. Kitchener and Harding (1990) pointed out that the services a client can offer are usually not as monetarily valuable as counseling. Thus, over time, clients could become trapped in a sort of indentured servitude as they fall further and further behind in the amount owed. Another potential problem concerns what criteria should be used to determine what goods or services are worth an hour of the therapist's professional time.

The practice of bartering could open up more problems than it is worth. As an example, consider a client who pays for therapy by working on the counselor's car. If the mechanical service is less than desirable, the chances are good that the counselor will begin to resent the client on several grounds: for having been taken advantage of, for being the recipient of inferior service, and for not being appreciated. The client, too, can begin to feel exploited and resentful if it takes many hours of work to pay for a 50-minute therapy session, or if the client believes the therapy is of poor quality. Feelings of resentment, whether they build up in the counselor or in the client, are bound to interfere with the therapeutic relationship.

Although bartering is not prohibited by ethics or law, most legal experts frown on the practice. Woody (1998), who is both a psychologist and an attorney, recommends against the use of bartering for psychological services because it could be argued that bartering is below the minimum standard of practice. If therapists enter into a bartering agreement with a client, Woody believes therapists have the burden of proof to demonstrate that the bartering arrangement (a) is in the best interests of the client; (b)

is reasonable, equitable, and undertaken without undue influence; and (c) does not get in the way of providing quality psychological services to the client. Because bartering is so fraught with risks for both client and therapist, Woody believes prudence dictates that it should be the alternative of last resort. Even if bartering is monitored carefully to lessen the chance of exploitation, there is a high risk of allegations of misconduct.

Although we can see potential problems in bartering, we think it is a mistake to condemn this practice too quickly or in all cases. In some cultures or in some communities, bartering is a standard practice, and the problems just mentioned may not be as evident. For instance, rural environments may lend themselves more to barter arrangements. We know a practitioner who worked with farmers in rural Alabama who paid with a bushel of corn or apples. Within their cultural group, this was a normal way (and in some cases, the only possible way) of doing business. Many different kinds of barter arrangements could be agreed upon between counselor and client. There are also alternatives to bartering, such as using a sliding scale, doing pro bono work, or referring the client to another provider.

Before bartering is entered into, it is important that the client and the counselor talk about the arrangement, discuss problems that might develop along with alternatives that might be available, gain a clear understanding of the exchange, and come to an agreement in writing. Bartering is an example of a dual relationship that allows some room for practitioners, in collaboration with their clients, to use good judgment and consider the cultural context in the situation.

Barnett and Johnson (2008) and Koocher and Keith-Spiegel (2008) agree that bartering with clients can be both a reasonable and a humanitarian practice when people require psychological services but do not have insurance coverage and are in financial difficulty. They add that bartering arrangements can be a culturally sensitive and clinically indicated decision that may prove satisfactory to both parties. However, because of the risk involved in bartering practices, they recommend carefully assessing such arrangements prior to taking them on. This is an area in which counselors would do well to seek consultation from a colleague who can provide an objective assessment of the proposed bartering arrangements. Of course, all of these steps should be documented in the client's clinical record.

Lawrence Thomas (2002), a clinical psychologist and a neuropsychologist, claimed that he never felt completely comfortable when he entered into a bartering arrangement, but each time he did so he believed bartering was the best alternative. Although bartering is a troublesome topic, it can be a legitimate means of helping out a person with financial difficulties. Thomas writes: "It can serve as a relatively dignified way for the patient to compensate the therapist for professional work" (p. 394). In his view, bartering should not be ruled out simply because of the slight chance that a client might initiate a lawsuit against the therapist. Thomas cautioned that venturing into any dual relationship requires careful thought and judgment and that the vast majority of professional work should be paid

by the usual monetary means. When this is not possible due to a client's economic situation, however, allowances should be made so that psychological services might be available. In short, bartering can be a way for the poor but needy client to obtain psychological services.

Thomas recommends a written contract, which should be reviewed regularly, that specifies the details of the agreement between therapist and client. Documenting the arrangement can clarify agreements and can also help professionals defend themselves if this becomes necessary.

- What is your own stance toward bartering?
- Do you see it as unacceptable in your own practice, or can you foresee instances when you might work out a barter arrangement that meets your professional code's criteria for ethical practice?
- What cultural factors would you consider in deciding whether or not to barter?
- What standards within the community would you consider?
- What alternatives to bartering might you consider with your clients who are unable to pay your fee?

Accepting Gifts From Clients

The cultural implications of gift-giving are recognized in the *ACA Code of Ethics* (ACA, 2014):

> Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and gratitude. When determining whether to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift. (Standard A.10.f.)

The AAMFT (2012) also has a guideline regarding gifts: "Marriage and family therapists do not give to or receive from clients (a) gifts of substantial value or (b) gifts that impair the integrity or efficacy of the therapeutic relationship" (3.10.).

Neukrug and Milliken (2011), in their survey of ACA members, found that approximately 89% of counselors believed it was unethical to accept a gift worth more than $25 from a client. In an earlier study, Borys (1988) found that only 16% of respondents believed that it was never or only rarely ethical to accept a gift worth less than $10, but the percentage of those who disapproved rose to 82% when the gift was worth more than $50. Apparently, the monetary value of gifts is a major factor for counselors in determining whether it is ethical to accept them. Although expensive gifts certainly present an ethical problem, it is possible to be overly cautious and, in so doing, damage the therapeutic relationship. Rather

than establishing a hard and fast rule, our preference is to evaluate each situation individually.

Other factors also need to be examined. Counselors need to be sensitive to cultural differences. As Derald Wing Sue, Christina Capodilupo, and Raul Machuca point out later in the chapter, gift-giving has different meanings in different cultures. The motivation of the client also needs to be considered. If the offering of a gift is an attempt to win the favor of the counselor or is some other form of manipulation, it is best not to accept the gift. It may be unwise to accept a gift without first having a discussion with the client. Gutheil and Brodsky (2008) maintain that the giving or receiving of gifts has layers of meaning, for both the client and therapy, that call for careful exploration. They suggest that in appropriate circumstances a gift may be helpful to therapy. Koocher and Keith-Spiegel (2008) contend that accepting certain kinds of gifts (highly personal items) is inappropriate and would require exploring the client's motivation. Counselors may want to inquire about the meaning to the client of even small gifts. According to Zur (2011), any gift must be understood and evaluated within the context in which it is given. Zur believes that expensive gifts or any gifts that create indebtedness, whether of the client or the therapist, are boundary violations. However, Zur claims that appropriate gift-giving can be a healthy aspect of a therapist–client relationship and can enhance therapeutic effectiveness.

The relationship that has developed between the counselor and the client should be considered. Offering a gift may be the client's way of expressing appreciation. For example, a client might bring a potted plant to a termination session as a way of saying "thank you" for the work that the counselor and client have accomplished together. If the therapist were to simply say "I cannot accept your gift," the client might feel hurt and rejected. Gutheil and Brodsky (2008) take the position that when clients offer a small gift at the end of therapy it is customary to accept the gift if it is appropriate and of insubstantial value. However, acceptance of other gifts might be improper. For example, a client who is a corporate executive might offer her counselor a stock tip based on her insider's knowledge. The counselor needs to explain to the client why it is improper to profit financially from information gained through a counseling relationship, and this could lead to a productive discussion about why the client felt a need to make such an offer. As is true of so many ethical dilemmas, one possibility is for the therapist to discuss his or her reactions with the client about accepting a gift.

One way to avoid being put in the awkward position of having to refuse a gift is to include a mention of the policy in your professional disclosure statement. The statement could include the information that, although counseling sessions may be intimate and personal, the relationship is a professional one and does not allow you to accept gifts. Although being clear with clients at the outset of the relationship does prevent some later

problems, there will be instances when small gifts are offered and might be received in the spirit in which they were offered. Rather than using a price tag or some other arbitrary criterion to determine the ethics of accepting gifts, the counselor might choose to have a full and open discussion with the client about the matter.

- In your own practice, would you ever accept a gift from a client? Why or why not?
- What criteria would you use in deciding whether to accept or refuse the gift?
- Would you ever be inclined to give a client a gift? If not, why not? If so, under what circumstances would you give a gift to a client?

Limits of Self-Disclosure

Counselor self-disclosure has been an issue of ethical concern as a result of research such as that conducted by R. I. Simon (1991), who found that inappropriate self-disclosure is the type of boundary violation that is most likely to precede sexual intimacies. Nonetheless, Neukrug and Milliken (2011) found that nearly 87% of surveyed counselors rated self-disclosing to a client as "ethical." Self-disclosure may be therapeutically beneficial or harmful, depending on a number of factors. The *purpose* of self-disclosure needs to be kept in mind. It is often relevant for a counselor to disclose his or her reactions to a client in the here-and-now of the therapy session, and this is more likely to have a therapeutic effect than disclosing details of one's personal life to a client. As with other counseling interventions, self-disclosure must be a thought-out process. We must determine whether our self-disclosures are clinically sound therapeutic interventions or subtle boundary violations. When counselors disclose personal facts or experiences about their lives, the disclosures should be appropriate, timely, and done for the benefit of the client. Yalom (2003) acknowledged that the therapist's practice of revealing aspects of his or her personal life can facilitate the therapeutic process, but he also suggests using caution.

If we find ourselves going into detail about our personal lives with our clients, we need to ask ourselves about our intentions and whose needs we are meeting. Clients are seeking our help for their problems, and they are not there to listen to our stories about our past or present struggles. Self-disclosure is a means to an end, not a goal in itself. If we lose sight of the appropriate professional boundaries with our clients, the focus of therapy might well shift from the therapist attending to the client to the client becoming concerned about taking care of the therapist.

A key ingredient in maintaining appropriate boundaries of self-disclosure is the mental health of the counselor. If we are not being listened to by our significant others, there is a danger that we might use our clients to satisfy our

needs for attention. Our clients might become substitute parents, children, or friends, and this kind of reverse relationship is certainly not what our clients need. Instead, when we have conflicts or unresolved personal concerns, we need to address them with a colleague, a supervisor, or a therapist.

A Contributor's Perspective

Fred Bemak and Rita Chi-Ying Chung present a multicultural and social justice approach to reconsidering boundaries in the therapeutic relationship. They develop the message that traditional models of counseling practice are grounded in assumptions that often are not effective when counseling people from diverse cultural backgrounds. They address a range of specific topics that call for adaptation to work from a multicultural and social justice framework. Some of the issues they address are community-based interventions, redefining self-disclosure, gift-giving, socializing with clients, the role of touch in counseling, bartering, and assuming alternate roles as helpers.

Cultural Boundaries, Cultural Norms: Multicultural and Social Justice Perspectives

Fred Bemak and Rita Chi-Ying Chung

Collectively we (Fred and Rita) have been working in cross-cultural and multicultural settings for five decades. A continual challenge in doing this work has been defining and maintaining boundaries with culturally diverse clients while providing counseling oriented toward social justice. A recurrent question we have both asked is how to broaden counselor–client relationships to incorporate culturally appropriate boundaries when working with clients who do not fit the traditional Western counseling paradigm. I (Fred) began my career working in an antipoverty program with ethnically diverse clients, and traditional boundaries accepted by the mainstream counseling profession were not applicable. I (Rita) am from a traditional Chinese background and was not born nor did I grow up in the United States. I have always challenged counseling and psychology definitions of boundaries and multiple relationships because they are incongruent with my Asian cultural worldview. If you are a mental health provider working in a multicultural setting, it is not surprising to me that you find dealing with boundaries and multiple relationships challenging.

Our role as helping professionals is to assist our clients in times of growth, change, and vulnerability. We believe that the power imbalance presents significant challenges for mental health professionals and has the potential to create ambiguity about one's professional role and responsibility. This belief was supported in a national survey of psychologists that found the second most challenging concern in their day-to-day practice was "blurred, dual, or conflictual relationships" (Pope & Vetter, 1992, p. 399).

Given the importance of professional boundaries and relationships, the major professional mental health organizations—ACA, APA, AAMFT, and NASW—all have codes of ethics that address the topic of boundaries and multiple relationships with an intent to define the role of the therapist that will lead to the best therapy for clients. However, the boundary definitions in these codes of ethics are based on Western cultural values (Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007). We are concerned that counselors working in cross-cultural or multicultural environments who adhere strictly to the Western counseling-based codes of ethics are in danger of losing their credibility. This may lead to client mistrust, premature dropout, and termination of therapy.

To compound the challenge of defining boundaries and relationships that were historically developed from a Euro-American framework is the dramatic racial and ethnic change in U.S. demographics, with rapidly growing numbers of people of color throughout the United States (U.S. Census Bureau, 2010). If we follow the changing racial and ethnic composition of the U.S. population, we can imagine the proportionate expansion of clients of color. Therefore, embedded in the increased cultural and ethnic diversity in the United States is a need to redefine counselors' roles and responsibilities to become better aligned with the expectations and understanding about the therapeutic relationship with clients of color. Traditional Eurocentric, individualistic theories define boundaries in counseling in ways that limit culturally responsive therapeutic relationships for diverse clientele, who may have different expectations about counseling and healing. This disparity in the definition of boundaries and multiple relationships between the mental health professionals and clients can have a negative effect on the therapeutic relationship (Chung & Bemak, 2012).

Adding to the complexity of culturally responsive counseling is the necessity for mental health professionals to be attentive to social justice concerns with their clients (Chung & Bemak, 2012). A danger in applying boundaries that are rooted in legality rather than culturally responsive or social justice orientations is reconstructing historical oppression, racism, discrimination, and shame that are experienced by clients of color (Vasquez, 2005), which may retraumatize clients. To move beyond the limitations of the traditional boundaries rooted in psychodynamic theory, counselors must at times become advocates and partners with clients, helping to change the inequities in the client's world, and facilitating culturally appropriate and justice-related healing within the context of the client's community (Bemak & Chung, 2005; Chung & Bemak, 2012). Taking on this advocacy role might involve counselors working with elders; spiritual, religious, and community leaders; or indigenous healers.

These multiple roles necessitate flexibility when interpreting current ethical standards and require that we create new ways of defining

boundaries and relationships that are responsive to cultural healing methodologies that have often existed for centuries. This leaves counselors trying to figure out their role and position with clients in relation to both culture and social justice. Counselors may experience anxiety and confusion in deciding which boundary crossings are acceptable and appropriate and how to cultivate a therapeutic relationship that is in the best interest of the client. Although the *Multicultural Counseling Competencies* (Sue, Arredondo, & McDavis, 1992; Sue et al., 1998) were established as guidelines for counselors to be culturally competent when working with clients from culturally diverse backgrounds, they do not address boundaries and multiple relationships across cultures or the ethical responsibility of a mental health professional in addressing social injustices.

In this section we would like to help you think critically about the importance of culture and social justice as important multidimensional and complex issues when considering crossing boundaries in counseling. Some boundaries are universal even when conducting multicultural and social justice counseling, such as counselors avoiding the misuse of their power by exploiting, disparaging, abusing, undermining, or harassing a client, or engaging in inappropriate behaviors and sexual relationships (Barnett et al., 2007). Lazarus (in Barnett et al., 2007) contends that all other aspects of ethics and boundaries are open for discussion. We agree that the Western psychological framework regarding boundary crossings must be reconsidered as it relates to clients from different cultural backgrounds and from oppressive life situations. It is especially important to rethink this framework given the rapidly changing ethnic and racial demographics in the United States and the numerous injustices that disenfranchised clients and communities encounter.

It is critical to examine seven issues as we adapt our practice and attend to multicultural and social justice boundary relationships:

1. *Community-based interventions*. Many communities of color are close-knit and foster a social level of engagement that is antithetical to Euro-American individualistically oriented cultures. The boundaries around relationships, confidentiality, and privacy established within communities of color are oftentimes much more loosely structured and based more on the African premise that "It takes a village to raise a child." Numerous times when we (Fred and Rita) have provided counseling in racial and ethnically diverse communities both in the United States and overseas, we have found there is much broader community involvement in a community member's problem and expectations that the neighbors and friends will become highly involved in providing both formal and informal psychological support. This collective involvement necessitates a very different construction of boundaries that is oftentimes at odds with traditional Western ethics codes regarding confidentiality and privacy.

2. *Redefining self-disclosure*. In ethnically and racially diverse communities there are expectations that the relationship becomes more than a formal, in-the-office, 50-minute session. Self-disclosure can contribute to the commonality shared with a client and can foster a greater sense of genuineness. In many cultures there is an expectation that counselors will share aspects of their personal lives, which in turn cultivates trust and openness. Self-disclosure is appropriate only when it is helpful for the client and serves to facilitate the therapeutic process, but it is important to remember that self-disclosure has the potential to be a powerful tool in building a connection with marginalized clients who have a history of oppression or culturally different clients who may be distrustful of the therapeutic process. For counselors not to self-disclose may create mistrust, loss of counselor credibility, client feelings of being unsafe, potential harm to the client, and premature termination. In Asian cultures self-disclosure may enhance rapport and enrich the counseling process (Kim et al., 2003). It is essential to keep in mind that crossing boundaries with clients from different cultural backgrounds requires knowledge, skills, competencies, and experience about the cultural, historical, and sociopolitical background of clients.
3. *Gift-giving*. In some cultures, exchanging gifts represents the spirit of helping, and giving back is a demonstration of one's appreciation and gratitude. For a mental health professional to reject a reasonable gift, or at times to withhold giving a gift, can be perceived as insulting and as a rejection of the client's culture. The expense and appropriateness of the gift must be considered, but it is important to keep in mind the cultural norms and the importance of showing respect and thankfulness by and to the client through the gift. Counselors must utilize their common sense with regard to gift-giving. One example of appropriate gift-giving happened when we were facilitating a parent and caretaker's counseling group in an urban African American community. There was a plan to celebrate a group member's 70th birthday in the group. Unfortunately, the member's granddaughter was ill the evening of the group meeting, so the grandmother couldn't attend. Both of us, along with other group members, drove to her home, which was located in a close-knit nearby community, brought a birthday cake, and sat on her front porch in the neighborhood celebrating the birthday. Many neighbors joined us in an animated discussion about problems, life, and healing. The trust established from this visit carried through with all the group members for the duration of the group. Another example relates to my (Rita) culture, in which it is customary for clients to bring food as a way of saying thanks. To reject the specially cooked food would be highly insulting.

4. *Socializing with clients*. In communities of color, everyone important in the client's life, including the counselor, is invited to join major social events. We have been asked to weddings, graduations, funerals, baptisms, birthdays, special cultural holidays, and community celebrations. Clients may perceive the rejection of these invitations as a lack of concern or care and, more important, a lack of a meaningful relationship. When we were invited by a client from Somalia to his mother's funeral, it was important for us to show our support for his grief and loss. To reject his invitation would have been an affront and would have caused great strain on the client–counselor relationship. One of our Brazilian colleagues, a well-established and sought-after psychiatrist, has made numerous house calls with clients, sharing meals, drinks, and social time with family members before engaging in home-based therapy. Not socializing with these clients, he explained, would have created serious obstacles in the therapeutic relationship.
5. *Touch is important and human*. How did boundary concerns move us away from human contact? In many parts of the world where we travel, communities are far more receptive to appropriate physical contact and touch. How did we become so phobic about appropriate touching, and why do we let litigation become a driving force in defining healthy, culturally responsive healing practices? Reaching out and making suitable physical contact with someone who is feeling alone and depressed, a child who is crying or in deep pain, or an individual sobbing after loss of loved ones in an earthquake is normal in many cultures. Both of us have held a crying child or an adult who was in deep pain after the loss of a loved one through terminal illness, suicide, a fatal accident, civil conflict, or a natural disaster. It is critical that we reassess the Western cultural norm regarding physical contact and begin to understand the meaning of touch for our diverse client populations. We are convinced that we must redefine appropriate boundaries regarding touch so that they are healing with racially and ethnically diverse clients. It is our experience that multicultural and social justice–oriented counseling must incorporate appropriate touch and physical contact.
6. *Bartering*. Many cultures are built on a bartering foundation. In addition, these clients may not have adequate resources to pay for counseling services. To effectively reach out and work with those without the financial means to pay standard counseling rates, address economic inequities, and provide multicultural social justice counseling from a culturally responsive framework, bartering is an excellent alternative to the traditional form of payment. Bartering must be thoughtfully worked out, keeping in mind the cultural context and the specific situation of each client. For example, when I

(Rita) worked with immigrants who had limited financial resources, the clients and I would discuss and agree on an exchange other than money as a form of payment. These clients visited an elderly person, helped out a person with disabilities, or tutored a newly arrived immigrant in return for counseling services. In other instances, both of us have worked out arrangements that were specific to clients, such as an exchange of home-baked goods by clients who were proud of their cooking skills, goods that were in turn shared with others and oftentimes donated to places such as homeless shelters, in return for counseling services.

7. *Different roles create different boundaries.* Attending to social justice issues and providing culturally responsive counseling requires us to take on different roles. At times we are advocates for our clients, at other times we are advisers, and sometimes we help generate social change in times of injustice or inequity. Still other times, mental health professionals find themselves being the liaison with culturally responsive healers such as elders and spiritual or religious healers. Each of these roles requires an expansion of traditional counseling responsibilities and functions from those based on the boundary definitions included in ethics codes. For example, we may become advocates to assist clients in gaining skills that would challenge discriminatory practices in their worksite, we may call on the Imam of the Mosque (mosque prayer leader) to speak with a client who is struggling with spiritual issues related to Islam, or we may become an adviser and provide directive interventions to a client coming from a culture where expectations are to receive explicit instructions from someone in an esteemed position like a counselor. Each of these singular roles requires a reconstitution of boundaries.

Final Thoughts

There is an inherent long-standing tension regarding boundaries and boundary crossings between the traditional psychodynamic model and the social justice approach of responding to racially and ethnically diverse clientele and oppressed populations. This tension mirrors much deeper divisions within the mental health field. It is imperative that we reexamine fundamental aspects of the counseling relationship that have a significant bearing on culture and social justice as a way to help us rethink the meaning, context, and practice of legality and humane practice that have bearing on social injustices and culture. As counselors we need to ask ourselves, “Whose boundaries are these?” “Do the boundaries help or hinder clients’ growth, development, and psychological well-being?” “If not, can we redefine the boundaries to more effectively respond to multicultural social justice issues facing clients?”

Alternative Counselor Roles in Working With Diverse Clients

Counselors today, regardless of the setting in which they work, are likely to encounter challenges in meeting the needs of diverse client populations. Working effectively with culturally and ethnically diverse clients may entail a willingness to assume nontraditional roles and to adopt various roles at different stages in the helping process. Some of this role shifting may look like multiple relating and crossing boundaries that are traditionally marked; however, combining roles may be necessary to counsel effectively in a multicultural community.

Counselors who work with ethnically diverse clients may need to shift their thinking because sticking with a singular role may limit their ability to reach these clients. According to Atkinson, Thompson, and Grant (1993), practitioners are generally best trained to play the role of psychotherapist, but this is the role most frequently misapplied in working with racial or ethnic minority clients. Atkinson and his colleagues believe that the conventional role of psychotherapist is appropriate only for clients who are highly acculturated and want relief from an existing problem that has an internal etiology.

Sue and Sue (2013) have criticized conventional approaches to therapy that focus on a client's intrapsychic conflicts and tend to place undue responsibility on clients for their plight. At the extreme, some interventions can be perceived as blaming client problems on the client rather than as examining real factors in the environment that may be contributing to the client's problem. Many of the writers with a community orientation have emphasized the necessity for recognizing and dealing with environmental conditions that often create problems for diverse client groups rather than merely working to change an individual client's behavior.

In selecting roles and strategies to use with diverse clients, Atkinson et al. (1993) believe it is useful to take into account the client's level of acculturation, the locus of problem etiology, and the goal of counseling. These writers and Atkinson (2004) have suggested that several alternative roles—advocate, change agent, consultant, adviser, and facilitator of indigenous support systems—are appropriate for counselors who work in the community. These alternative counselor roles embody fundamental principles of social justice and activism that are aimed at client empowerment. Rita Chi-Ying Chung and Fred Bemak stated that at times they are advocates for their clients, at other times they are advisers, and sometimes they focus their efforts on social change to combat injustice or inequity. Each of these roles requires an expansion of traditional counseling responsibilities and functions.

Later in this chapter Derald Wing Sue and Christina Capodilupo describe the necessity for counselors to become competent carrying out nontraditional roles and reaching diverse members of a community. One

of these roles is assuming the role of advocate when cultural groups are oppressed by the dominant society. Counselors can speak on behalf of clients who are low in acculturation and need help with problems that result from discrimination and oppression. Chung and Bemak (2012) contend that by adhering to traditional roles, mental health practitioners are maintaining and reinforcing the status quo, which results in politically supporting the social injustices, inequalities, and discriminatory treatment of certain groups of people. Chung and Bemak view becoming an advocate for empowerment as a central core of counseling that involves time and making a commitment to this goal. They take the position that advocacy is an ethical and moral obligation for becoming an effective counselor. The *ACA Code of Ethics* (ACA, 2014) acknowledges the importance of advocacy for clients whose problems result from discrimination and oppression (Standard A.7.), and the *Code* includes the promotion of social justice as a core value of the profession.

In the role of *change agent*, counselors can make use of political power to confront and bring about change within the system that creates or contributes to problems that clients face. In this role, counselors assist clients to recognize oppressive forces in the community as a source of their problems and teach clients strategies for dealing with these environmental problems. A change agent recognizes that healthy communities produce healthy people. In their role as change agent, counselors must at times educate organizations to change their culture to meet the needs of the community.

By operating as *consultants*, counselors often assume the role of teacher. They can encourage clients from various ethnic groups to learn skills they can use to interact successfully with various forces within their community. The client and the counselor work together collegially to address unhealthy forces within the system and to design prevention programs to reduce the negative impact of racism and oppression.

The counselor as *adviser* discusses with clients ways to deal with environmental problems that are contributing to their personal problems. This is much like a social work approach that considers the person-in-the-environment rather than addressing problems as residing solely within the individual. For example, recent immigrants may need advice on coping with problems they will face in the job market or that their children may encounter at school.

For many ethnically and culturally diverse clients, seeking help in the form of traditional counseling is foreign. Often they are more willing to turn to social support systems within their own community. By acting as *facilitators of indigenous support systems*, counselors can encourage clients to make full use of the resources in their communities, including community centers, extended families, neighborhood social networks, churches, and ethnic advocacy groups. Counselors need to learn what kinds of healing resources exist within a client's culture. In many cultures, professional

counselors have little hope of reaching individuals with problems because these individuals are likely to put their trust in folk healers, acupuncturists, and spiritual healers who are a part of their culture. At times, it may be difficult for counselors to adopt the worldview of their clients, and in such instances it could be helpful to *make a referral to an indigenous healer*. Counselors can then structure their activities to complement or augment the healing resources available for the client.

For counselors who hope to reach a diverse range of client populations, it is essential to be able to employ therapeutic strategies in flexible ways and to assume various roles in helping clients. Combining roles will be necessary to help many clients effectively. Counselors who assume a social justice orientation are not merely concerned with bringing about changes within the individual; rather, they are interested in instigating social change. Competent multicultural and social justice counseling calls for practitioners who are familiar with community resources, know the cultural background of their clients, have skills that can be used as needed by clients, and have the ability to balance various roles. For thoughtful discussions of case examples of social justice programs and re-envisioning the practice of counseling, we recommend *Helping Beyond the 50-Minute Hour: Therapists Involved in Meaningful Social Action* (Kottler, Englar-Carlson, & Carlson, 2013). For comprehensive discussions of social justice and systems changes as applied to working with diverse client populations, see *Social Justice Counseling: The Next Steps Beyond Multiculturalism* (Chung & Bemak, 2012).

A Contributor's Perspective

Derald Wing Sue and Christina Capodilupo expand on some alternative roles in helping that may be implemented in various communities. They eloquently present an ethical framework for viewing dual or multiple relationships from a multicultural perspective. Their contribution shows how boundaries take on special meaning when working in the community.

Multicultural and Community Perspectives on Multiple Relationships

Derald Wing Sue and Christina Capodilupo

Mental health professionals are increasingly being confronted with situations that challenge the standards of practice and codes of ethics developed by their professional associations (Sue & Sue, 2013). Such is the case with dual or multiple relationships. Once counselors have entered into a therapeutic relationship with a client, the role they play becomes relatively prescribed. Traditionally, that role has been defined as working for the "therapeutic good" of clients, avoiding undue influence, allowing clients to make decisions on their own, setting clear boundaries, and main-

taining objectivity by preventing personal bias from entering counseling decisions. It is believed that such a therapeutic relationship is sacrosanct, and indeed ethics codes have arisen around it to protect clients from being "taken advantage of" or "harmed."

Codes of ethics have clear guidelines that warn against multiple relationships because such relationships potentially compromise the therapeutic role. There is good reason for the existence of these standards, and some psychologists assert that relationship boundaries should remain rigid and well defined. Others have begun to raise questions and issues regarding the universal application of such standards to all situations, problems, and populations, suggesting that multiple relationships are not necessarily problematic, especially in the context of small communities (Schank & Skovholt, 2006; Sue, Ivey, & Pedersen, 1996). First, concepts of mental health, the therapeutic process, and the roles helping professionals play are grounded in modern Euro-American culture. Some cultural groups may value multiple relationships with the helping professional. Second, some dual or multiple relationships may be unavoidable. This is especially true in smaller towns and rural areas where there are very few mental health professionals (Campbell & Gordon, 2003; Schank & Skovholt, 2006). Finally, some mental health professionals believe that multiple relationships based on nontraditional helping roles may be more beneficial than harmful. For example, it has been suggested that multiple relationships may facilitate the use of mental health services among those in rural areas (Schank & Skovholt, 2006); communities of color (Pedersen, 1997); religious communities (Case, McMinn, & Meek, 1997); and the lesbian, gay, bisexual, and transgender (LGBT) communities (Graham & Liddle, 2009).

The multicultural counseling and therapy movement has sensitized many to the fact that standards of normality and abnormality, the counseling role, and what is considered therapy are culture bound (Parham, 2002; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002; Sue & Sue, 2013). In Asian culture, for example, it is believed that intimate matters (self-disclosure) are most appropriately discussed with an intimate acquaintance (relative or friend). Self-disclosing to a stranger (counselor) is considered taboo and is a violation of familial and cultural values. Thus certain Asian cultures may encourage a "dual" or "multiple" relationship in which the helper is also a relative or close personal friend. An Asian client's desire to have the traditional counseling role evolve into a more personal one is often perceived by a Euro-American–trained counselor as inappropriate and manipulative. In addition, gift-giving is a common practice in many Asian communities to show gratitude, respect, and the sealing of a relationship (Sue & Sue, 2013). Such actions are culturally appropriate, yet counselors unfamiliar with such practices may feel that it is inappropriate to accept a gift because it blurs boundaries, changes the relationship, and creates a conflict of interest. They may politely refuse the gift, not realizing the great insult and cultural meaning of their refusal for the giver.

In direct recognition of this cultural consideration, the *ACA Code of Ethics* (ACA, 2014) specifies that "counselors . . . recognize that in some cultures, small gifts are a token of respect and gratitude" (Standard A.10.f.).

The multicultural counseling movement has also challenged the traditional roles played by counselors who work in the community. Most counselors are taught that therapy is conducted in an office environment, is directed toward remediation, and is a one-to-one process. They are taught that the counselor is relatively inactive and that clients must make the decisions and take responsibility for their own actions. Yet in many cultural groups, including among African Americans, Hispanic/Latino(a) Americans, and Asian Americans, clients prefer to receive advice and suggestions because they perceive the counselor to be an expert with higher status who possesses special knowledge and expertise. The roles they find helpful may not be the traditional counseling role but other, more active roles. Atkinson et al. (1993) and Atkinson (2004) have identified different helping roles that the professional needs to develop to become multiculturally competent and to work effectively in the community. These roles are associated with client needs and characteristics: internal versus external locus of the problem, level of acculturation/knowledge of the home culture, and whether the overall goal is one of remediation or prevention. Playing more than one of these roles implies the establishment of a dual or multiple relationship. Similarly, LGBT therapists often find themselves in overlapping relationships with LGBT clients who share their communities. It has been suggested that LGBT therapists need to maintain flexibility and constantly negotiate personal and professional boundaries in an effort to effectively manage these multiple relationships (L. E. Kessler & Waehler, 2005).

In smaller communities and in our historical past, it was not unusual for citizens to play multiple roles such as storekeeper, neighbor, teacher, and friend. With increasing urbanization, such cross-mixing of relationships has become rare in the cities. As Forester-Miller and Moody discuss later in this book (Chapter 11), a counselor or therapist in a smaller community may find it exceedingly difficult not to have other relationships with her or his clients. Similar assertions have been made for LGBT therapists (Graham & Liddle, 2009).

Our codes of ethics now recognize that multiple relationships may be unavoidable, that not all such relationships are harmful, and that under certain conditions they may even be therapeutically beneficial. A helpful distinction was made between boundary crossing and boundary violation by Zur and Lazarus (2002). A boundary crossing is a harmless and often helpful deviation from traditional clinical practice, whereas a boundary violation is a departure from accepted practice that is harmful and exploitive. These scholars argue that boundary crossings are likely to "increase familiarity, understanding, and connection and hence increase the likelihood of success for the clinical work" (p. 6). In general, the guidelines

discouraging dual relationships are well intentioned and basically sound. However, they must not be rigidly applied to all situations. As we have seen, community characteristics (rural versus urban, small versus large, LGBT, and community acceptance of certain practices such as bartering), multicultural redefinitions of counseling roles, and cultural perceptions of helping practices must be considered. Given the fact that counselors may unavoidably find themselves in a dual relationship or faced with a potential one, what guidelines can be used to minimize harm? Here are a few suggestions to consider:

- Personal and professional integrity must be the guiding force behind a decision to enter a dual relationship or to maintain one. Counselors must consider the good of the client first and not allow personal or professional agendas to interfere with the therapeutic relationship. The decision must be based not solely on "good intentions" but on whether the relationship actually impairs or harms the therapeutic goals or whether the risks for harm are too great. Mental health professionals should assess whether they are using the power differential to exploit their client in any way.
- Counselors must be thoroughly knowledgeable about their profession's code of ethics and the spirit in which it was developed. Written statements cannot cover all situations. Many, like the examples given earlier, are not covered by clear guidelines, and to stick to "the letter of the law" may harm clients. Adhering to a dichotomous definition of the therapeutic relationship may obscure subtleties in cultural expectations and prevent effective treatment (Glass, 2003).
- Counselors must educate themselves about cultural and community standards of practice. For example, if a counselor decides to accept a gift from a client or to accept barter as a means of exchange, the actions must be judged according to the client's cultural context and by the community's normative standards.
- If a counselor does not feel comfortable with a dual relationship or if it contains too many potential risks, it is the responsibility of the counselor not only to make this clear to the client but also to offer alternative means by which services can be obtained (other community resources or helpers).
- It is unrealistic to expect any single helping professional to rely solely on self-monitoring as a means for avoiding problematic dual relationships. In all situations when a counselor considers entering into or is unavoidably involved in a dual relationship, it is recommended that consultation with colleagues be sought. Indeed, continual consultation and monitoring of the situation must be the cornerstone of any continuing dual relationship.

A Contributor's Perspective

Derald Wing Sue and Christina Capodilupo make it clear that as counselors working in the community, we need to rethink and revise our traditional definitions of therapeutic boundaries if we are to reach and serve a multicultural clientele. Thomas Parham and Leon Caldwell agree that boundaries need to be reconsidered by multiculturally competent counselors, and they discuss multiple relationship issues from an African-centered worldview.

Boundaries in the Context of a Collective Community: An African-Centered Perspective

Thomas A. Parham and Leon D. Caldwell

We explain the African-centered worldview in more depth here to provide guidance to students, practitioners, and supervisors who are challenged to express this worldview against a backdrop of Eurocentric standards regarding relationships. We intend to offer a reprieve to those who themselves are or who provide counseling to culturally conscious African Americans.

In an earlier edition of this book, Parham (1997) contended that framers of ethical standards have anchored their objections to dual relationships in several primary themes. First, dual relationships are discouraged because they potentially compromise the clinician's objectivity and professional judgment. Apparently, it is believed that secondary and tertiary relationships increase the probability that professionals will develop strong emotional ties that potentially compromise their ability to make objective decisions. Second, dual relationships are discouraged to prevent the helpee (either client or student) from projecting inappropriate dependency needs onto the helper. A third rationale centers around the power differential between helper and helpee and the degree to which those dynamics contribute to or invite helpee exploitation by the professional. The latest revision of the APA (2010) ethics code has lessened the imperative to "avoid at all costs" any dual or multiple relationships and now reflects a more culturally sensitive caveat that dual and multiple relationships must be appropriately managed to avoid exploitation. However, many codes of conduct continue to place blanket prohibitions against dual and multiple relationships. The inherent epistemological and axiological assumptions of these codes should be examined because they may, in fact, prove to be an obstacle or hindrance when working with African American clients.

Helms and Cook (1999) extended this notion that ethical standards represent barriers for some ethnic communities by observing that the standards themselves have been influenced by traditional theoretical perspectives. They imply that cultural conflicts potentially emerge when strict

adherence to Eurocentric ethics codes bumps up against other cultural mores, values, and traditions that have different foundational values. They further caution that cultural conflicts that result from rigid ethical and professional guidelines can lead to negative therapeutic consequences such as cultural conflict, client confusion, and early termination.

To understand the foundation of relationships in an African-centered context, one must first understand the role of a healer, why relationships have power, and why boundaries are permeable rather than rigid. Within the context of an African-centered therapeutic space, counseling professionals are considered to be healers. Healers participate "with their clients" rather than "on their clients" in helping them to confront their intellectual, emotional, behavioral, and spiritual debilitations (Hilliard, 1998; Parham, 2002). Healers recognize that the resolution of personal challenges occurs through many forms and across many contexts. Therefore, to limit their space is to diminish their opportunity to practice their healing art. Fu-Kiau (1991) articulated this idea by reminding us that therapy in an African context is not confined to a mental health professional's office, nor is it conducted in strict 50-minute hours. Therapy involves multiple activities and can include conversation, but also play, shared meals and cooking, travel, rituals and ceremony, singing or drumming, storytelling, writing, touching, and laughter.

For example, therapy can be conducted while the client and therapist are taking a casual stroll through a neighborhood park or outdoor area near the office. Assignments and suggestions can also be given in which the client may be invited to engage in a playful activity, cooking experience, or journaling exercise. Each of these activities, when performed by the client, has the potential to bring a "healing focus" to the experience. Although the therapist may engage in some of these activities with the client, it is likely that the client will adopt some of these activities and perform them in the absence of the therapist. In this way, the client begins to understand the healing process.

1. Being "open" to healing experiences is a first step in enhancing a client's self-healing power.
2. Healing can occur anywhere and at any time, including spontaneous experiences with unplanned events, or even people one meets by chance.
3. People and events become "healing" not simply because they exist or occur but because they instigate a thought, feeling, or spiritual insight that helps the client to appreciate some aspect of the self that he or she might have been struggling to understand.

Consequently, a healing aspect of therapy in a traditional office setting might include giving the client a hug to end the session. It may include performing a ritual with the client (e.g., sharing a libation) at the

beginning of the session or processing the particular aspects of a recreational activity the client engages in while the therapist is in attendance and observing the client.

Fundamentally, Africans and people of African descent live in a collective world and see every action in terms of a collective community. Unlike the Eurocentric focus on individuals as independently functioning entities, people of African descent belong to a group and derive their power from the collective energy of the group, tribe, or family. Healers must recognize this and utilize the community in all of its aspects as potential healing places and spaces.

The nature of relationships for African American practitioners and clients is inherently dualistic. Professional standards of conduct, training environments, and practices that disregard alternative cultural perspectives on relationships place culturally conscious African American students and practitioners at risk for ethnic community alienation or professional misconduct.

In understanding the role of a healer, it is also important to understand why relationships have power. People in many African cultures believe that each person is endowed with a spirit or life force that is divinely inspired. That energy is often referred to as an individual's "self-healing power" (Fu-Kiau, 1991). An individual's power can be diminished by being out of balance with his or her rhythm and natural order or by becoming too distant from the energy of the collective community. Thus therapeutic practice, irrespective of theoretical orientation, is not simply viewed as an art of healing but as a practice of regenerating an individual's self-healing power. That regeneration occurs through the interaction of therapist and patient, whose relationship creates a synergy that is transformative. Thus therapeutic practice in an African-centered context has less to do with boundary issues or dual relationships and more to do with what is transformative or healing within a specific therapeutic context.

In remembering that imperative, one can now see why African-centered ethics codes begin and develop in a concern for the quality of human relations. A fundamental African principle states that human beings realize themselves only in moral relations to others. Unlike Eurocentric ethical standards, which appear to be designed to control people's behavior, African-centered ethics invite people to aspire to "right ways of being." The African worldview fundamentally believes in the ontological principle of consubstantiation; that is, elements of the universe are of the same substance. There is an interconnectedness between the helper and the helpee, and developing and maintaining emotional and spiritual connections is considered facilitative.

In recognizing that professionals and students alike may have difficulty navigating their way through different culturally congruent and incongruent sets of ethics codes of conduct and professional standards of practice, perhaps there is a need for some suggested methods of approach. We offer the following helpful hints to the African American students

and professionals, their supervisors (irrespective of cultural background), training programs, and service delivery agencies and organizations who are invested in applying more culturally sensitive ethics to their practice.

Helpful Hints for African American Trainees

- Be aware of all the professional standards and guidelines that exist within the entire professions of psychology and counseling.
- Be aware of the ethical standards that are adopted in the agency in which you work or train.
- Be cognizant of your position and cultural expertise in the community.
- Be aware of the client's worldview and how it might influence your application of particular ethical principles.

Helpful Hints for Supervisors of African American Trainees

- Develop awareness of your own cultural competence, including your limitations.
- Develop awareness of cultural expectations held by African American and other culturally different trainees and how those might vary by level of racial identity development.
- Acknowledge that when dealing with African Americans supervisees may be more culturally aware and confident about certain aspects of their work than the supervisor.

Helpful Considerations for Professional Therapists

- Examine your own interpretation of the ethical guidelines and how those inform your practice.
- Engage in some deep thinking about how ethical guidelines may affect your work with particular clients.
- Make appropriate use of the consultation process with colleagues who are more culturally competent and those who can render judgments that broaden the options to consider.
- Support policies that recognize that dual relationships are inherent and culturally expected.

Considerations for Training Programs

- Acknowledge multiple perspectives on relationships.
- Train students in ways that highlight relationship management rather than relationship avoidance.
- Teach awareness of exploitation and harm by encouraging peer consultation.
- Help trainees examine what drives the decision-making codes (mandatory ethics versus social constructivism).
- Acknowledge when individual cultural competence may conflict with organizational or institutional competency guidelines. Practitioners can advocate for policy change, education, and general awareness of institutional conflict when this occurs.

- Teach trainees to share with the community what our professional ethical obligations are and how they affect our strengths and limitations.
- Develop a clear, articulated decision-making strategy prior to facing an ethical problem.

Considerations for Agencies and Organizations

- Conduct a cultural audit to examine ways in which the organization's policies and practices might affect the client base served by that agency.
- Examine agency protocol and how power and decision making are used to address cultural competence through ethical practice.
- Recognize that there are multiple perspectives on interpreting ethics codes and professional standards regarding boundaries.
- Conduct retreats and periodic meetings to review ethical standards and dilemmas challenged by developing levels of cultural competence within the agency.

Summary

It is important to consider boundaries and dual relationship standards when we provide services to clients or students in our professional roles. However, it is also important to take into account cultural traditions and value systems that differ markedly from those underlying the standards embraced by professional associations as we develop appropriate roles and responsibilities for a profession that is becoming increasingly multicultural. Conducting one's affairs in ways that adhere to established professional codes of conduct can be a challenge. This is particularly true when those standards are congruent with only one cultural perspective to the exclusion of others, and the clients are culturally different as well. Boundary issues are only one element in a list of ethical standards that needs to be examined for cultural sensitivity. In doing so, we enhance our own level of cultural competence and help to ensure that those whom we counsel and teach are treated in ways that best address their needs, and not just our own.

A Contributor's Perspective

Our next contributor, Raul Machuca, draws on his own experience as a Latino immigrant and as a counseling student and counselor in the United States to address boundary issues from a Latino perspective.

Boundary Issues in Counseling Latino Clients

Raul Machuca

Perceptions of boundaries and boundary crossings are intimately related to the cultural backgrounds of both the client and the counselor. In this

contribution, I refer to my personal experience as a Latino clinician to illustrate ways in which certain boundary issues may arise in working with Latino clients as well as ethical and therapeutic ways of addressing them. As a Latino immigrant, my perception of boundaries has evolved as a consequence of my own acculturation process in the United States and as a result of continuous negotiation between my cultural values and the values of a Eurocentric counselor education process.

Different cultural groups may not necessarily understand the concept of boundaries in the same way as those who have a Western Eurocentric mentality. For Latino clients, particularly those with a lower level of acculturation, it is quite difficult to comprehend the mere existence of a rigid professional boundary between them and a counselor to whom they have revealed their most intimate secrets. For Latino clients, it is not necessarily clear that a therapeutic relationship is different from a personal relationship. The distinctions may not be clear to Latino counselors, either. In my case, I realize that I am going through an acculturation process parallel to that of my clients.

Although difficult to achieve, a clear understanding of how boundaries and boundary crossings play a role in working with Latino clients is a basic tool in facilitating more culturally sensitive and effective work within this population. The negotiation of boundaries to facilitate a more effective therapeutic relationship with Latino clients is a sign of cultural competence. With Latino clients, clinicians need to be attuned to Latinos' appreciation for a greater degree of personal warmth, the desire to relate to the counselor at a more personal level, a greater level of comfort with affection and touching, and closer personal space, all while maintaining the professional hierarchical relationship that is expected in the U.S. culture.

My understanding of how boundaries function in the therapeutic relationship has been a process that started during my days as a Latino graduate student from Colombia. As an international student, I was mainstreamed into what seemed to me to be a rigid Eurocentric way of becoming a professional counselor. I remember, for instance, finding it difficult to grasp the idea that we could listen and have an empathic conversation with someone and remain within the constraints of ethical, legal, and cultural rules. One of the first things that I noticed was the significant difference between myself and some of my American classmates in terms of understanding and establishing clear and definitive boundaries with clients from the outset of the therapeutic relationship. It just did not feel quite right for me to make it clear to a client from the beginning that everything we talked about was confidential, but that confidentiality was not absolute because there were specific instances in which I was mandated to report. In my primitive counseling mind at that time, I imagined myself going to a counselor who would tell me that and thinking that I could not entirely trust him. I also struggled with messages that, again in my primitive counseling mind, sounded like

absolute commands: no touching, no self-disclosure, no accepting of gifts. As a Latino, the idea that I could not shake my client's hand, talk about myself, or even accept gifts felt somewhat cold, distant, and even disrespectful. At that time, I remember that my strategy to deal with this "cultural dissonance" was (apart from meeting unavoidable legal requirements) to simply relate to my Latino clients using a greater degree of personal warmth than with my non-Latino clients.

Working with Latino clients presents many opportunities for boundary crossings that can help establish a more effective therapeutic relationship. Some of the most common boundary crossings I have encountered as a Latino clinician working with Latino clients are related to the perception of and adherence to time limits, self-disclosure, gift-giving, participation in family and social events, and community interactions.

A general stereotype about Latinos is that they have a different perception of the importance of time, particularly in terms of punctuality and time management. There is what we call "Colombian time," although it applies to other Latino groups, which basically means that it is somewhat socially acceptable and expected to be fashionably late. Although this wasn't present among all my Latino clients, I remember having to plan my schedule to account for these late arrivals, especially for the first sessions. Another time-related boundary that needed to be stretched, for both my clients and for me, was having a predetermined amount of time for sessions. As a beginning clinician, I struggled with the mere idea of having a session that could not go beyond 50 minutes. Time limits were also regularly ignored by my Latino clients, many of whom expected our interactions to go on as long as they felt it was necessary. I remember having very long sessions and struggling to end many of them. Later, I learned to structure my sessions by incorporating a more realistic agenda to make it clear that the sessions would come to an end once specific goals were met.

Another issue that I often encounter as a Latino counselor is self-disclosure. In my early process of acculturation, I found it difficult to balance being completely genuine with what I perceived as rigid commands of the counseling profession: "avoid self-disclosure, "do not respond to personal questions," and "state specific limits about interactions." As I gained more experience, I realized that establishing rapport was easier with my Latino clients if I was prepared to respond to personal questions rather than avoiding them, exploring their intentionality, or stressing the client-focused nature of our interactions. I was typically asked about my country of origin, time in the United States, marital status, and even family composition. I also realized that sometimes my clients would not ask but would make assumptions about me. My way of dealing with this was to maintain the assumption without actively deceiving the client: Unless I was asked directly, I would not volunteer information even when I perceived that the client may have assumed something about me that could have been inaccurate. Many of the assumptions were positive and facilitated a greater level of identification and opportunity to re-

late. The most typical assumptions were related to perceived common experiences for Latin Americans such as the immigration process, socioeconomic status, cultural values, and religious beliefs.

As a Latino, I knew that refusing a gift could be considered a grave offense for my Latino clients. I also knew that as part of the dynamics of our professional relationship I had to expect clients to feel a need to reciprocate the help gained from counseling. Often, there was from the beginning an understanding that I would be offered something, particularly food, as a symbolic appreciation for my services. I struggled with negotiating what would be acceptable to receive and how to politely refuse any excess of generosity. In many cases, the negotiations came down to a glass or bottle of water, with the occasional surprise of a special traditional dish.

In Latino culture, once you get to know the family secrets you become part of the family. Therefore, invitations to all sorts of family events were a constant in my practice. I found that openly refusing an invitation did not work to help establish and maintain a strong therapeutic relationship. I came to realize that just considering the possibility of attending was sometimes enough to convey my appreciation of a client's gesture, even if I could not or simply decided that I would not attend.

Finally, to facilitate the specific needs of Latino clients and ensure a successful counseling experience, it helps to provide opportunities for Latino clients to relate to you as a person, although this entails boundary crossings that may not be required when working with other populations. In my case, the fact that I am a Latino counselor working with Latino clients makes it quite common that our social lives sometimes overlap. A common situation in which boundaries are tested at the social level has to do with being open to unsolicited advice given by clients on all sorts of issues such as health, cultural events, and in my case, Latino-related shopping and groceries. I remember a client who asked me if I had visited a store she recommended as soon as she knew I was Colombian. She wanted me to try what she considered the best Colombian empanadas in town. When I did and told her that I had done so, I realized how significant it was for her to feel that she could reciprocate the support she felt she was receiving from me.

In conclusion, addressing boundary issues with Latino clients requires clinicians to become familiar with the cultural values of this population and make a special effort to accommodate the clients' values into the somewhat more rigid Eurocentric approach to counseling. As an immigrant Latino counselor, walking the acculturation path alongside my clients has helped me to appreciate the importance of being flexible.

A Contributor's Perspective

Our next contributor, Mevlida Turkes-Habibovic, draws on her own experience to address boundary issues from a Muslim perspective. She suggests the importance of distinguishing between Muslim clients' religious and cultural beliefs.

Boundary Considerations in Counseling Muslim Clients

Mevlida Turkes-Habibovic

As has been noted, contemporary literature suggests that boundary crossings sometimes can be appropriate and have therapeutic value. For practicing Muslims in the United States, some counselor behaviors that might be considered boundary crossings in the Euro-American counseling worldview are seen as a natural part of a helping relationship.

Although the ethics codes of the mental health professions acknowledge diversity and cultural sensitivity, religion and its influence on clients' lives seems to be overlooked. Religion and culture are used as interchangeable terms, and the lines between them are often blurred. However, the distinction is important when counseling practicing Muslims. It is critical to understand both the religious and the cultural beliefs of practicing Muslims. Often, religious identity overshadows cultural identity. For example, an African American Muslim and a European immigrant Muslim may have very different cultural backgrounds yet may be much alike with respect to the overarching importance of religion in their lives.

I believe that integration of religion into therapeutic conversations improves counseling services to clients for whom Islam is an integral part of their lives. Lack of trust in service providers with other religious backgrounds is not uncommon among Muslims. If Muslims could rely on the integration of their religious beliefs into the counseling process, the underutilization of services among this population might be significantly reduced.

Religious coping, founded on Qur'anic and Prophet Muhammed's (pbuh) teaching, is an important aspect of Muslim life. Religious coping may involve reading the Qur'an in both Arabic and the client's native language, reading hadiths (Prophet's [pbuh] sayings), making supplications, giving to charity, performing voluntary prayers, gathering the Islamic perspective about the issue in question, seeking help from an Imam, and utilizing indigenous treatment methods. Religious coping is relevant to counseling, has therapeutic value, and could be considered a form of bibliotherapy that could be appropriately incorporated into therapy. Counselors could use the client as a source of this knowledge, and they could greatly benefit from consultative relationships with Muslim religious leaders and local Imams. Although many differences exist among Muslims in the United States, Islam is the factor that unifies their daily activities and experiences. It is important for counselors to discuss with the client the role that Islam has in his or her life. Rather than waiting for the client to self-disclose this information, it is beneficial for the counselor to explore it in the initial session; this would not only influence rapport but also increase trust, especially if the counselor has a different religious background. Being open to exploration of a Muslim client's religious identity in the early stages of the therapeutic process is a way to enhance the

therapeutic relationship, the therapeutic process, and the counselor's multicultural competence and at the same time empower the client.

Counselors could examine their attitudes toward Muslims and their knowledge about Muslims and Islam and ask themselves, "What, if any, is the influence of my attitudes and knowledge about Muslims on my approach, problem conceptualization, and work with this population?" Muslims in the United States are a racially and ethnically diverse population that include converts and born Muslims from all over the world. Muslims in the United States are not only Arabs or Asians, as often perceived, but are also Europeans, Latinos, Africans, Native and African American–born Muslims, and converts. In fact, the majority of Muslims in the United States are African Americans (Gallup, 2009).

Islam is an integral part of daily life for Muslims, although Muslims differ in their adherence to Islamic practices and values. For example, a practicing Muslim woman may not accept a male counselor, and practicing Muslim spouses may expect marital counseling founded on Islamic values. It is important for counselors to distinguish between Muslim clients' religious and cultural beliefs. For example, marriage between cousins is permissible in Islam and is a common practice among some Muslims, such as Arabs or Asians, but this practice is not only uncommon but culturally unacceptable among others, such as Bosnian Muslims. On the other hand, religious Muslim spouses, regardless of their ethnic background, may have similar matrimonial relationships founded on Islamic teaching. They may expect and benefit from marital counseling integrated with their religious view of marriage. Muslim spouses who adhere to religious practices to a lesser extent may have different views of the marital relationship based on cultural convictions common to their ethnic group.

If therapy occurs during Ramadan, a month of fasting from sunrise until sunset (no drinking and eating of anything), a counselor could make arrangements so the client could perform a prayer, or could offer a session in the morning, as the fast is arduous, especially during the long summer days. A client may ask to perform the prayer in the counselor's office because intentionally missing one of five daily prayers is a major sin. Practicing Muslims would rather miss a counseling session than one of the mandatory prayers.

It is common for Muslims to invite others for iftar (a dinner right after sunset during the fasting month of Ramadan) at their home or at a mosque. Declining the invitation could negatively affect the therapeutic relationship. Although accepting the invitation could be challenging for a counselor of a different background, it could be a rewarding experience (especially if an iftar is served at a mosque) that would help the counselor understand the client's values, lifestyle, and available community resources. If a dinner is served at a mosque, it is expected that men and women will sit separately and that proper attire will be worn, such as long sleeves, long skirt/pants, and a scarf for women and a shirt with sleeves and pants below the knees for men.

In Islamic practice, interactions between men and women are minimalized, and some Muslim clients may request and accept only a counselor of the same gender for individual counseling. The choice of counselor for marital or family counseling may be more flexible because another person, specifically a mahram (an unmarriageable man for that specific woman, such as her father, brother, or uncle), might be present during a session. Some Muslim clients, both men and women, may not shake hands with a person of the opposite gender. Others may accept a handshake but might think they have committed an inappropriate act and feel guilty. It is best if the counselor allows a Muslim client to choose whether or not to greet in this way.

Because of Islamic beliefs about lowering one's gaze, some Muslim clients may not maintain eye contact with a counselor of the opposite gender. If the counselor maintains eye contact, the client might consider this inappropriate, and it could make the client uncomfortable.

For counselors who hope to reach Muslim clientele and reduce their underutilization of counseling services, a proactive and innovative approach is needed. Rather than waiting for Muslim clients to visit an office or an agency, a counselor could establish a collaborative relationship with local Imams and offer counseling services at a mosque. Liaison with local Imams is very important. Also, Imams could be invited as guest lecturers in classrooms and community mental health agencies. Counselors could offer support and consultation to Imams in their work because Imams are familiar with community dynamics and their job duties include counseling and advising community members. If there is more than one mosque in the greater Muslim community, I strongly recommend establishing working relationships with all local Imams, if possible, to better understand the differences and similarities among diverse Muslim populations.

In conclusion, it is important to consider that Muslims may lack trust in counselors of different religious backgrounds. To build trust and increase utilization of counseling services, counselors can use Islamic teaching as a resource when applicable, such as using examples from the Qur'an and Sunnah (Prophet Muhammed's [pbuh] life) in marital counseling, and religious coping in both individual and marital counseling, to meet the needs of this population. Religion and religious coping are sources of resilience for many Muslims during stressful times in their lives. Counselors need to examine how their attitudes toward Muslims and their knowledge about them may affect their work with this diverse population. By becoming aware of Muslim religious beliefs and related daily activities, counselors can begin to explore how these might be relevant to counseling specific Muslim clients. Counselors need to work within the boundaries set by their clients' beliefs and values, including religious beliefs and values, and be mindful of cultural and practicing variations among Muslims.

Conclusions

The multicultural and social justice orientation to counseling has many implications for rethinking what counselors consider to be appropriate therapeutic boundaries. The eight guest contributors to this chapter presented very diverse cultural perspectives, yet they identified a common theme in the need for flexibility in defining boundaries related to gift-giving, self-disclosure, social relationships with clients, and community involvement. Many, many additional cultural perspectives could have been included in this exploration of boundaries, which we think underscores the richness of the possibilities for improving counseling services to diverse client populations.

Chapter 5

Issues in Counselor Education

Numerous dual relationship issues present themselves in the counselor education and training process. Some of these issues involve subtle and complex questions about where boundaries should be drawn when counselor educators play multiple roles and have multiple responsibilities with their students. In this chapter we explore relationship boundary concerns that commonly arise in counselor education programs and present the thoughts of several guest contributors. Kristina A. Peterson and Holly A. Stadler team up to present a faculty perspective. They identify potential areas of conflict in the various roles taken by counselor educators and students and suggest that prudence and ethical reasoning are essential in creating an ethically sound training environment. Kristen N. Dickens writes about the multiple roles that doctoral students often play.

The focus questions that guide us through our discussion include the following:

- What are the implications for counselor educators and students of the 2014 revisions to the *ACA Code of Ethics*?
- What kinds of conflicts do counselor educators face in the multiple roles they fulfill in their work?
- Can some forms of role blending in the professor–student relationship be beneficial?
- What are the responsibilities of counselor educators in teaching students about dual and multiple relationships? How can the issues best be raised and explored, and how can students be prepared to deal with dual or multiple relationship dilemmas?

The *ACA Code of Ethics* (ACA, 2014) addresses the issue of relationship boundaries between student and professor and between student and student quite extensively. The need to establish and maintain appropriate and effective boundaries in teaching, training, and supervision is stated in the Introduction to Section F:

> Counselor supervisors, trainers, and educators aspire to foster meaningful and respectful professional relationships and to maintain appropriate boundaries with supervisees and students in both face-to-face and electronic formats. They have theoretical and pedagogical foundations for their work; have knowledge of supervision models; and aim to be fair, accurate, and honest in their assessments of counselors, students, and supervisees.

Clearly, there are parallels between the counselor–client relationship and the professor–student relationship. In both types of relationship, it is the responsibility of the person in the more powerful position to define and maintain appropriate boundaries and to engage the person in the less powerful, more dependent position in ongoing discussion and explanation to prevent problems when possible and to resolve them when they do arise.

Two standards of the *ACA Code of Ethics* (ACA, 2014) address different aspects of nonprofessional relationships between counselor educators and students. One standard addresses the risk of potential harm to the student, and the other identifies the potentially beneficial aspects of such relationships:

> Counselor educators avoid nonacademic relationships with students in which there is a risk of potential harm to the student or which may compromise the training experience or grades assigned. In addition, counselor educators do not accept any form of professional services, fees, commissions, reimbursement, or remuneration from a site for student or supervisor placement. (Standard F.10.d.)

> Counselor educators are aware of the power differential in the relationship between faculty and students. If they believe that a nonprofessional relationship with a student may be potentially beneficial to the student, they take precautions similar to those taken by counselors when working with clients. Examples of potentially beneficial interactions or relationships include, but are not limited to, attending a formal ceremony; conducting hospital visits; providing support during a stressful event; or maintaining mutual membership in a professional association, organization, or community. Counselor educators discuss with students the rationale for such interactions, the potential benefits and drawbacks, and the anticipated consequences for the student. Educators clarify the specific nature and limitations of the additional role(s) they will have with the student prior to engaging in a nonprofessional relationship. Nonprofessional relationships with students should be time limited and/or context specific and initiated with student consent. (Standard F.10.f.)

Sexual Dual Relationships

The *ACA Code of Ethics* (ACA, 2014) explicitly forbids counselor educators from engaging in sexual or intimate relationships with students or subjecting them to sexual harassment of any kind:

> Counselor educators are prohibited from sexual or romantic interactions or relationships with students currently enrolled in a counseling or related program and over whom they have power and authority. This prohibition applies to both in-person and electronic interactions or relationships. (Standard F.10.a.)
>
> Counselor educators do not condone or subject students to sexual harassment. (Standard F.10.b.)

For some time, the codes of ethics of other professional associations also have had prohibitions against sexual dual relationships between students and educators: The American Psychological Association (APA) code has included such a provision since 1992, and the American Association for Marriage and Family Therapy since 1988. The current APA (2010) code states that "psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority" (7.07.).

The American Psychiatric Association (2013b) provides a rationale for avoiding sexual involvement in education and training:

> Sexual involvement between a faculty member or supervisor and a trainee or student, in those situations in which an abuse of power can occur, often takes advantage of inequalities in the working relationship and may be unethical because:
>
> a. Any treatment of a patient being supervised may be deleteriously affected.
> b. It may damage the trust relationship between teacher and student.
> c. Teachers are important professional role models for their trainees and affect their trainees' future professional behavior. (4.14.)

Despite these clear statements in codes of ethics of professional associations, faculty–student sexual relationships do occur, although it is difficult to estimate the incidence rate. Studies conducted during the 1990s (G. M. Miller & Larrabee, 1995; Thoreson, Shaughnessy, & Frazier, 1995; Thoreson, Shaughnessy, Heppner, & Cook, 1993) found that 5% to 6% of female counselors and about 4% of male counselors experienced sexual contact with their professors or supervisors while they were students. Several studies (Glaser & Thorpe, 1986; Hammel, Olkin, & Taube, 1996; G. M. Miller & Larrabee, 1995) have indicated that women's attitudes toward their experiences change over time. In retrospect, they believe their

sexual contacts with professors were more coercive, more of a hindrance to the working relationship, and more damaging to their professional careers than they believed at the time. These studies raise questions about students' ability to consent freely to such relationships and about how prepared students are to deal with the ethics of such intimacies. Moreover, educators and supervisors tend to have professional power and authority long after direct training ends.

In their study of psychologists who reflected on their sexual relationships with clients, supervisees, and students, Lamb, Catanzaro, and Moorman (2003) found that 1% of the total sample reported a sexual boundary violation with a supervisee and 3% reported a sexual boundary violation with a student. The majority of these violations occurred after the professional relationship had ended (100% after supervision and 54% after teaching). Approximately half of the respondents indicated that they had terminated the professional relationship (therapist, supervisor, teacher) so that they might initiate or continue the sexual relationship. The respondents in the study were asked to identify the circumstances or reasons that influenced their decisions to pursue these sexual relationships. Three general types of reasons and circumstances were given:

- "No harm, thus I proceeded" (40% of the responses).
- "Consulted and/or negotiated" (32% of the responses).
- "Continued although I knew the behavior was problematic and/or unethical" (28% of the responses).

Not only are sexual relationships between faculty and students prohibited by the ethics codes, they also create a modeling effect (Kress & Dixon, 2007) that could lead to students' later exploitation of their clients. Kress and Dixon point out that when there is a sexual relationship with a faculty member, or former faculty member, it often makes it difficult for the student to establish and maintain appropriate boundaries with clients. The counselor educator is in a position of power, and acting on sexual attractions with students or trainees can lead to a multitude of negative outcomes both personally and professionally.

Role Conflicts for Counselor Educators

Self-Growth Experiences

Counselor educators confront some nonsexual relationship boundary issues that are inherent in the very nature of counselor training. It is well accepted in the profession that the counselor's personal characteristics influence therapeutic outcomes. This assumption makes it incumbent on counselor training programs to focus on counselors-in-training as people as well as on evaluating their academic performance. Students need to develop a strong sense of self-awareness along with an understanding of interpersonal dy-

namics if they are to become effective counselors. Thus counselor training programs blend academic study and experiential or personal learning, and counselor educators are expected to use sound professional judgment when they conduct training exercises that require student self-growth or self-disclosure. The *ACA Code of Ethics* (ACA, 2014) states that

> Self-growth is an expected component of counselor education. Counselor educators are mindful of ethical principles when they require students to engage in self-growth experiences. Counselor educators and supervisors inform students that they have a right to decide what information will be shared or withheld in class. (Standard F.8.c.)

As counselor educators, we grapple with some key questions. Although we don't "grade" self-growth experiences, how can we avoid unintentionally incorporating knowledge gained through students' self-disclosures in our evaluations of their performance? When student limitations are personal or interpersonal rather than academic, what are the most effective ways to address those limitations? How can we encourage students to be alert to signs of potential impairment and to seek professional assistance to remediate problems that are interfering with their ability to provide services to others? (See ACA, 2014, Standard F.8.d.)

Gatekeeper Role

One of the major goals of counselor education programs is to promote and facilitate competence and professional behavior in their students. Counselor educators are faced with the task of identifying, dealing with, and possibly dismissing students who are not making satisfactory progress toward professional competence (Oliver, Bernstein, Anderson, Blashfield, & Roberts, 2004). Counselor education programs have an ethical responsibility to screen candidates so the public will be protected from incompetent practitioners. Programs have a dual responsibility: to honor their commitment to the students they admit and to protect future consumers who will be served by those who graduate. Counselor educators serve as gatekeepers to the profession. They protect consumers by identifying and intervening with graduate students who exhibit problematic behaviors (Vacha-Haase, Davenport, & Kerewsky, 2004). In a Delphi study conducted by Herlihy and Dufrene (2011) to get experts' opinions regarding the most critical current and emerging ethical issues encountered by the counseling profession, gatekeeping was ranked second most important (by 89% of participants) in counselor preparation.

Role conflicts can occur because we encourage students to become personally involved in their training program and, at the same time, we also serve as gatekeepers to the profession. As counselor educators, we have the task of balancing our mentoring role with our evaluative role. As mentors, we encourage students to develop personally and professionally

by taking risks, and we support students in the process of accomplishing their goals. As evaluators, we sometimes are required to see that students take action when they exhibit problematic interpersonal behavior. Not only are we concerned about assisting our students in acquiring knowledge and skills, but we also are invested in helping them to assess their personal strengths and limitations that will affect their professional work. It is essential to evaluate trainees' professional behavior, clinical performance, and professional competence and to identify those interpersonal behaviors and personality characteristics that are likely to influence trainees' abilities to effectively deliver mental health services. At times, conflicts may arise as counselor educators try to manage the dual roles and responsibilities of mentoring and evaluating counselor trainees. Increased attention has been given in the literature to evaluating problematic student behavior and dismissing students in professional programs. With the increased awareness of the damage mental health professionals who do not possess the personal qualities necessary for effective practice can cause, there is an ethical mandate for training faculty to serve as gatekeepers for the profession (Johnson et al., 2008).

Evaluation of Personal Factors

According to the *ACA Code of Ethics* (ACA, 2014), counselor educators are responsible for ongoing evaluation of students' didactic and clinical competencies (Standard F.9.a.) and are aware of any personal limitations of students that might impede performance (Standard F.9.b.). Rather than using the term *impairment* to refer to trainees who are not meeting minimum standards of professional competence, Kress and Protivnak (2009) prefer the term *problematic counseling student behaviors* because it focuses on problematic behaviors without labeling the student as impaired. Possible problematic behaviors include poor clinical skills; poor interaction with faculty, supervisors, and colleagues; and inappropriate self-disclosure with clients. When students are unable to provide competent service due to certain limitations, counselor educators are expected to assist students in securing remedial assistance when it is needed. If remediation efforts are unsuccessful, counselor educators may be required to dismiss students from the program or refuse to endorse them for completion of the program. When dismissal is the course of action taken, it is essential that counselor educators seek professional consultation, document their decision, and provide students with due process. Counselor educators "ensure that students have recourse in a timely manner to address decisions requiring them to seek assistance or to dismiss them and provide students with due process according to institutional policies and procedures" (ACA, 2014, Standard F.9.b.).

Certainly, if counselor educators do not attempt to help students become aware of personal factors that could impede their functioning as counsel-

ors, they are neither doing them a service nor helping their future clients. As personal problems or limitations of students become evident, faculty members have an ethical duty to encourage students to face and deal with these issues lest these factors impede their performance as helpers. If students who have unresolved personal issues or who hold rigid and dogmatic attitudes, values, or prejudices are allowed to graduate from training programs, then it can hardly be said that the welfare of the consumer is being considered seriously. We think programs should provide, as part of the curriculum, opportunities for students to examine their personal lives, with special emphasis on their needs, motivations, and life experiences that may affect their abilities to function effectively as practitioners.

Ethical quandaries sometimes arise when instructors become aware of personal problems or limitations of students through a nongraded experiential component of a course. It might be a dyadic practice session between two students in which one is serving as the counselor and the other as the counselee; it might occur in an experiential portion of a group counseling class; or it might emerge in exploring the student's difficulties in working with a certain client in practicum. If instructors raise their concerns with these students in a way that leads to a negative evaluation or an administrative action, students may feel that their trust was betrayed, no matter how carefully instructors have explained in advance any possible repercussions. Yet counselor educators cannot ignore their serious concerns about students; they have an ethical responsibility to monitor the profession.

Sometimes students who have personal characteristics or problems that interfere with their ability to function effectively deny the feedback they receive. A program has an ethical responsibility to take action rather than simply pass on a student with serious academic or personal problems. Training programs need to establish written policies regarding the way in which personal psychotherapy might be either recommended or required to remediate a student's problems (Elman & Forrest, 2004).

Informed Consent and Orientation to a Program

The preceding discussion underscores the importance of providing informed consent for students in counselor training programs. Students need to know that becoming an effective counselor entails more than mastering a body of knowledge and acquiring counseling skills. They also need to be made aware of the importance of their personal characteristics and their ability to function effectively in the interpersonal realm. Students must understand how their personal qualities are directly related to their ability to competently perform in the clinical area. The personal growth aspects of a program need to be made known to prospective students prior to their entrance into a program. Because many of us challenge students to think about their personal lives and their values and invite them to explore a range of feelings, students have a right to know where

there may be potential problems. We ought to tell our students what we are doing to ensure that we are keeping their interest and welfare in mind, and we should talk about the procedures and practices we use to minimize the potential negative consequences of any role blending. Although program policies need to be initiated early in a training program, it is not sufficient to address these policies and procedures at the time of orientation. This discussion needs to take place throughout the training program to prepare trainees for potential difficult conversations pertaining to their own professional competence (Jacobs et al., 2011).

Relationship Boundaries Between Students and Professors

In the first edition of this book (Herlihy & Corey, 1992), we raised the question of whether a counselor educator should ever counsel a student. At that time, we noted that this was one of the most controversial questions pertaining to dual role relationships of counselor educators, and two guest contributors presented contrasting points of view. The *ACA Code of Ethics* (ACA, 2014) provides an answer to this question: Standard F.10.e. states clearly that "counselor educators do not serve as counselors to students currently enrolled in a counseling or related program and over whom they have power and authority."

Although counselor educators should not enter into formal therapeutic relationships with students, this does not mean that we must remain aloof and distant from our students as persons. In the first edition, Lloyd (1992) raised a concern that counselor educators might be developing a "dual relationship phobia." He cautioned that no constituency (institution, student, or profession) is well served when counselor educators avoid the struggles of making responsible decisions by hiding behind a prohibition against multidimensional relationships. His concern was that opportunities for live demonstrations of individual and group counseling, and for supervision with a personal focus, might be lost if counselor educators approach dual relationship issues too conservatively.

We agree that it is as possible to err on the side of caution as it is to err on the side of carelessness about relationship boundaries. Mentoring relationships, as we noted in Chapter 1, are not dual relationships of the type that the *Code* is intended to discourage. A mentor serves as an adviser, confidant, friend, teacher, and supervisor—and the mentee can benefit a great deal from this special relationship. Mentoring often involves collaborative research efforts, and conflicts can arise around such issues as giving credit for publication of research findings.

Two standards in the *ACA Code of Ethics* (ACA, 2014) provide safeguards to ensure that counselor educators do not take unfair advantage of their more powerful positions. The first requires that students be given adequate credit for their contributions to research: "Counselors who

conduct joint research with colleagues or students/supervisors establish agreements in advance regarding allocation of tasks, publication credit, and types of acknowledgment that will be received" (Standard G.5.e.). The second addresses students as principal authors: "Manuscripts or professional presentations in any medium that are substantially based on a student's course papers, projects, dissertations, or theses are used only with the student's permission and list the student as lead author" (Standard G.5.f.). For mentoring relationships to work as they are intended, it is essential that professor and student talk candidly beforehand to establish clear working guidelines and that an open dialogue is maintained.

Other types of role blending occur in the counselor training process. Live class demonstrations of counseling can enhance student learning and in-class "real-plays" by students in the client role can be instructive so long as students understand clearly that they are in charge of the type and extent of their self-disclosure. Counselor educators certainly can remain ethical and relate to students on an unstructured and personal level, making themselves available to students beyond class time and office hours. Issues raised during a class session are often continued over a cup of coffee after class, professors attend graduation parties of their doctoral students to extend their congratulations, and graduate student associations sponsor social events as well as lectures and other educational opportunities. None of these or other, similar situations need be problematic.

Bowman, Hatley, and Bowman (1995) assessed both faculty and student perceptions of dual relationships in mentoring, friendships, monetary transactions, informal social interactions, and romantic/sexual relationships. They observed that certain dual relationships are unavoidable in most training programs and suggested that dual relationships may be more accurately evaluated when viewed from the perspective of how the faculty member and student *behave* within the relationship, rather than concluding that the mere existence of a dual role is necessarily unethical.

According to Burian and O'Connor Slimp (2000), multiple role relationships may at first appear benign, and sometimes even beneficial, yet they pose some risks. For example, the mentoring that occurs between faculty and students may include social elements, which can be beneficial to the student. However, Burian and O'Connor Slimp suggest ending or postponing the social relationship if more than a minimal risk of harm exists. The ultimate ethical responsibility rests with the individual with the greatest power, in this case, the counselor educator.

Biaggio, Paget, and Chenoweth (1997) observe that faculty–student relationships are not static and that some multiple roles and overlapping relationships are to be expected. Students progress from the beginning stages, to graduation, and eventually to becoming colleagues with faculty members. Biaggio and her colleagues presented three general guidelines for faculty in maintaining ethical relationships with students. First, faculty members need to recognize the potential for harm in dual relationships with their

students and that they hold a position of power and authority over students. Second, faculty need to have a framework for evaluating appropriate and inappropriate conduct and monitor contact carefully so students are not harmed or exploited. Third, faculty need to model appropriate and ethical relationships with other professionals, students, and clients.

Above all, counselor educators must not exploit students and trainees or take unfair advantage of the power differential that exists in the context of training. Managing multiple roles ethically is primarily the counselor educator's responsibility. Counselor educators who are able to establish appropriate personal and professional boundaries are in a good position to teach students how to develop appropriate boundaries for themselves.

Dual Relationships Between Students

In doctoral programs, advanced students are often involved in the supervision of students who are seeking their master's degrees. The supervision of students by students raises a potential for problematic dual relationships, even though such an arrangement has many potential benefits. When students are involved in leading counseling groups or providing clinical supervision for their peers, "counselor educators make every effort to ensure that the rights of students are not compromised when their peers lead experiential counseling activities in traditional, hybrid, and/or online formats (e.g., counseling groups, skills classes, clinical supervision)" (ACA, 2014, Standard F.7.g.).

Careful supervision and monitoring are needed to ensure that problematic dual relationship problems between students are avoided whenever possible and that they are resolved when they do occur.

A Contributor's Perspective

Kristina A. Peterson and Holly A. Stadler provide a thoughtful discussion of the various roles played by counselor educators and students. They discuss the importance of prudence in ethical decision making and offer suggestions for managing ethical dilemmas in the training environment.

Dual Relationships in Counselor Education

Kristina A. Peterson and Holly A. Stadler

Boundary issues continue to be vexing ethical concerns despite the guidance provided in ethics codes. The *ACA Code of Ethics* (ACA, 2014) is replete with references that clarify the responsibilities in the multiple professional roles and relationships that are characteristic of the profession. The extensive literature in counseling ethics is certain to include boundary issues when taking up the obligations of ethically sensitive professionals. This focus on dual relationships often takes the central theme of sexual relationships in clinical settings. This is the case as well when discussing

boundary issues in counselor education. Other forms of dual relationships receive less attention but are important sources of concern for counselors and counselor educators in training.

In this contribution we discuss the multiple roles and relationships that are common in counselor education programs. We view the dilemmas of counselor educators who once were students and now are faculty in counselor education programs. Holly Stadler offers her perspectives as a dean of a college of education housing a counselor education program. Also informing this discussion is commentary on the ever-changing ways technology interfaces with human relationships, including troubling dual relationships.

Like all relationships, educational relationships have the potential for harm. Unfairness, favoritism, and conflicting interests are some of the negative consequences of boundary violations. Similar to boundary mismanagement in the clinical setting, the consequences of education-related boundary problems extend beyond the immediate participants to many affected parties: other students, program faculty, future faculty, the reputation of the training program, and ultimately the public's view of and reliance on the counseling profession.

Multiple Roles and Relationships

Counselor education programs provide the training ground for the development of an awareness of professional ethical obligations. They are laboratories for the instruction and modeling of ethical consciousness and ethical decision making. The opportunity to observe and engage with ethically sensitive faculty and peers enables counselors and counselor educators in training to hone the sensibilities and skills that are essential to the practice of the counseling profession. In the training venue, the types of multiple relationships that are experienced in many life settings may find their way into the educational environment where they can be viewed under the ethical microscope and an ethically sound course of action can be determined. In a learning environment, multiple roles offer multiple opportunities for instruction and modeling.

As a preventive measure, it is useful to anticipate some possible role and relationship conflicts that could develop as counselor educators fulfill their academic responsibilities in multiple roles of educator, supervisor, adviser or mentor, researcher, and colleague. We also discuss multiple peer roles and relationships in programs that serve both master's and doctoral students.

With respect to the *educator* role, consider that the objectivity of the selection and evaluative aspects of the educator role (such as admission decisions or assignment of grades) can be compromised by noneducational roles that involve, for example, business, social, or familial relationships. These noneducational dual relationships can be cause for concern. The *ACA Code of Ethics* (ACA, 2014) cautions counselor educators to "avoid nonacademic

relationships with students [and, by extension, future students] in which there is a risk of potential harm to the student or which may compromise the training experience or grades assigned" (Standard F.10.d.).

Awareness of boundary issues that could develop when teaching courses that involve student self-disclosure and personal growth, such as a counseling skills class, group counseling, practicum, and internship, is also important. Courses such as these often require students to role-play therapeutic scenarios in which they act as clients. In many cases, students discuss authentic personal concerns, which might affect evaluative decisions by a faculty member. Students and educators can refer to Standard F.8.c. of the *ACA Code of Ethics* (ACA, 2014), which discusses management of self-growth experiences in training programs.

Relationships that are fraught with potential for boundary mismanagement are advisory or mentoring relationships. We believe that these types of relationships have more ambiguous expectations than teaching and supervisory relationships because they involve the idiosyncratic personalities and life experiences of the educator and the student. Such relationships have the potential for either participant to meet her or his own achievement and recognition needs through the successes of the other. Concerns can arise when educators come to depend on advisory or mentoring relationships to meet their own social needs or their needs for psychological intimacy.

To recognize a common dual relationship for faculty in the *researcher* role, reflect on the faculty member conducting research on counselor education who directly solicits students in counselor education classes to participate in a study. This scenario frequently comes to the attention of institutional review boards at universities. For our purposes, however, it is important to note that students in this situation might either believe their participation will gain some advantage over other students or feel coerced to participate in a faculty study. Another issue with regard to the role of the faculty researcher occurs when the researcher takes on the role of *employer* of research assistants. Having a clear description of the duties of the research assistant helps to avoid the possibility of boundary problems. When a student's financial well-being is dependent on holding a research assistantship, the potential for coercion or neglect of academic goals can occur. Without examination of the ethical aspects of relationships in the training environment, the opportunity for a boundary violation could arise. For example, a former graduate research assistant described her experience as requiring personal tasks such as picking up dry cleaning and pet sitting as part of her duties.

Dual roles in *collegial* and *administrative* counselor educator relationships are also potential sources of conflicting interests and obligations. For example, consider colleagues who are in a business partnership or who are intimate partners. Serving together as members of a curriculum committee might not produce any inordinate conflicts beyond those that already take

place in such a committee. But if one of the partners is in a position to evaluate the other for tenure or merit pay, there could be serious ethical concerns. Questions of objectivity and the interests being served could overshadow the actual record of the person under review. Conflicting interests may deter candor and cloud judgment when untenured faculty members are in selection or evaluation roles regarding an applicant, student, or colleague who has a dual relationship with a tenured faculty member.

In programs that serve both master's and doctoral students, boundary issues in *peer* relationships also require attention. As part of their training program, doctoral students engage in various multiple roles: student, teaching assistant, instructor, supervisor, supervisee, counselor, group counselor, and peer/classmate (Scarborough, Bernard, & Morse, 2006). Conflicts between personal and professional roles can be particularly difficult for students to navigate. Boundary issues occur when doctoral students have trouble negotiating their role as a student versus their role as an instructor or supervisor of master's-level students. These situations require faculty to model ethical behavior as well as provide supervision surrounding such dilemmas.

One of the difficulties faced by doctoral students in addressing boundary issues is that the multiple relationships in which they find themselves are dynamic rather than static (Scarborough et al., 2006). There may be preexisting or co-occurring personal or professional relationships between doctoral-level and master's-level students. Situations and roles can change from semester to semester throughout the student's training program, making it more troublesome to avoid the potential pitfalls in maintaining ethical boundaries.

Boundary Issues and Technology

We are all aware of the many resources that counseling students can access through the Internet that broaden their perspective and supplement course instruction and textbooks. The ability to, for example, view and review multiple demonstrations of counseling skills, access examples of actual school guidance lessons, and observe the behaviors of real-life or simulated persons exhibiting various psychiatric diagnoses adds immensely to the learning experience. Course support software and technology-enabled communication enhances the ability of faculty and students to interact outside the classroom.

One might ask how technology has affected the issues that arise with respect to boundary maintenance in counselor education. The speed of technology-enhanced communication and the tendency to make quick and possibly poorly reasoned responses might lead to ethical concerns. A critical first step of ethical decision making is the capacity to recognize when one faces a dilemma. Taking time to reflect on a situation enhances this ability and provides time for you to ask some important questions:

"What is the ethical course of action?" "Which ethical virtues should inform my behavior?" The rapid pace of online communication in service of the norm of instantaneous responding is not consistent with good ethical decision making.

A further technology-focused problem in boundary maintenance is the capacity to reach a large audience purposefully or in error. For example, a boundary crossing message between a faculty member and a student mistakenly sent to a group list makes public what was private communication, harming many in the process. A reliable test to determine an ethical course of action is the test of publicity: Would your behavior stand up to outside scrutiny? Would you want a headline describing your behavior to appear on the front page of a newspaper? The widespread use of communication technology adds another series of questions to that test: Would you want this behavior available for all to observe on social media sites? Would you want this email message sent to "reply all"? The speed and scope of technology in documenting and disseminating information requires exemplary ethical diligence on the part of all engaged in any aspect of counselor education.

Managing Ethical Quandaries in the Training Environment

I (Holly Stadler) have participated on and chaired state and national counseling ethics committees. Many complaints that come before those bodies are due to imprudence and lack of sound ethical reasoning. As mentioned earlier, the training environment is a necessary locus of instruction, supervision, and modeling of prudence and reason in dual relationship situations. Ethical sensitivity in professional life requires both the intellectual tools to formulate justifications for conduct and the disposition to do good. Counselors-in-training can learn to make informed ethical choices based on a reasoned account of the nature of the circumstance, the application of ethical principles as action guides, and the development of a course of action (Kitchener, 1984; Stadler, 1986). Ethics course work and practicum/internship supervision are typically opportunities for instruction and modeling in ethical decision making (Urofsky & Sowa, 2004). These opportunities also prepare students to anticipate common ethical concerns such as child abuse reporting (Stadler, 1989) and to use ethical reasoning strategies to articulate justifications for possible courses of action. Infusion of topics of ethical concern in all aspects of the curriculum and in research projects further alerts students to the various manifestations of ethical dilemmas and the operation of ethical principles while modeling ethical sensitivity.

Ethical decisions based on the application of moral principles help to answer the question, "What should I do?" Virtue ethics help in reflection on the question, "What kind of person should I be?" Prudence is one of a group of virtues or traits of character that augment principle-based

decision making. Pellegrino and Thomasma (1993) have described prudence as the "indispensable connection between cognition of the good and the disposition to seek it in particular acts" (p. 84). Prudence moves us from thought to action in the moral domain. Some (Meara, Schmidt, & Day, 1996; Pellegrino & Thomasma, 1993) believe that prudence is the defining virtue of professional moral life. Meara and colleagues (1996) have described prudence as "appropriate restraint or action, deliberate reflection upon which moral action to take, an understanding of the long-range consequences of choices made, acting with due regard for one's vision of what is morally good, and a knowledge of how present circumstances relate to that good or goal" (p. 39).

Students usually enter counselor education programs with their character traits well formed. Careful selection procedures have been used to identify applicants who are best suited for the profession. If the profession is concerned about monitoring ethically troublesome dual relationships, then the virtue of prudence might be one character trait to look for in the candidate selection process. During the course of training, faculty can support, model, and habituate this character trait through reinforcement and demonstration of the general practice of prudence (for example, clinical prudence), not merely prudence in ethical matters (Wilson, 1993). The exercise of prudence requires the type of reflection that is not typical of the norm of instantaneous technology-enabled communication. Helping students navigate dilemmas and reflect on situations that might test a student's prudence (such as crisis intervention) can augment general reflections on the question, "Who do I want to be as an ethically sensitive counselor?"

Concluding Comments

In an ethically congruent training environment, counselor educators and counselors-in-training are guided by a sense of mutual respect and respect for the counseling profession and for those served by the profession. We acknowledge the conflicts and complexities of dual relationships. Through the exercise of prudence and ethical reasoning, the boundaries of multiple roles and multiple relationships can be managed effectively so as to respect all those engaged in and served by the counseling profession.

We agree with Peterson and Stadler's contentions and believe that multiple roles frequently come into play in counselor education. Apart from sexual relationships with students, which are clearly unethical, a wide range of dual and multiple relationships exist that are part and parcel of the training process. Rather than lumping all these nonsexual multiple relationships as unethical along with sexual relationships, professional training ought to focus on teaching students how to manage situations involving multiple roles and relationships.

A Contributor's Perspective

Kristen Dickens reflects on some of the multiple roles she has been challenged to manage as a doctoral student: student, graduate assistant, coteacher, coauthor, copresenter, coach, supervisor, supervisee, employee, and leader in a student organization.

Multiple Roles That Doctoral Students Play

Kristen N. Dickens

Many types of multiple relationships in counselor education environments need to be approached with caution and prudence, but it can be asserted that multiple relationships are natural for students and faculty in higher education, especially at the doctoral level. I have often heard students and faculty refer to multiple relationships as "wearing many hats," which I find to be an accurate metaphor. In my pursuit of a doctoral degree in counselor education, I have engaged in the following roles: student, graduate assistant, coteacher, coauthor, copresenter, coach, supervisor, supervisee, employee, and Chi Sigma Iota chapter board member. Before delving into my experiences with multiple roles, let me describe the beginning of my journey.

I remember reading about the roles and responsibilities of doctoral students in different counselor education programs when I was considering pursuing a doctoral degree. I found that there were required roles and suggested roles. For example, some programs required doctoral students to supervise master's students and teach one or multiple classes. Others suggested roles such as completing research projects with faculty, presenting at conferences (sometimes with faculty), and joining academic organizations. Many programs offered forms of assistantships, including research, teaching, practicum and internship, or general program assistantships. I would soon discover that reading about multiple roles and responsibilities is drastically different from actually engaging in them.

Perhaps the most salient experiences of engaging in multiple roles as a doctoral student resulted from my role as a graduate assistant. Prior to starting my first semester in my doctoral program, I was offered a graduate assistantship working for the faculty. Thus, from the outset of my doctoral journey, I participated in the roles of student and graduate assistant. At the new student orientation, I was provided with a program handbook and a separate graduate assistantship handbook that clearly outlined the roles and responsibilities. Depending on the needs of the program, my assistantship role and duties would vary. Initially my roles included communicating with graduate school staff and the administration regarding graduation documents and student records. Later I became the graduate assistant to the faculty member in charge of practicum and internship, which I will later discuss. Because of the proximity of my office to the offices of my program

faculty, I frequently interacted with them, as well as with current doctoral and master's students. I also held meetings with prospective program applicants and handled application materials. I assisted with prospective students' interviews and new student orientations and often fielded questions and concerns of current master's and doctoral students.

It was during these initial semesters serving as a graduate assistant that I really learned what it meant to "wear multiple hats" and the importance of drawing boundaries—with both faculty and students. For example, part of my role included serving as an intermediary between students and faculty, faculty and graduate school staff, students and graduate school staff, prospective program applicants and faculty *and* graduate school staff. Other graduate assistants and I set appointments with prospective applicants who often had first contacted faculty to discuss applying to the program. If faculty were unable to meet with the prospective students, we were required to speak with them. When prospective students applied to the program, I assisted with the handling of their application materials, making sure the graduate school in addition to our program received certain documents, and I contacted the students when documents were missing. When my graduate assistantship duties were redirected to assisting the practicum and internship faculty coordinator, I experienced the peak of my anxiety and frustration when engaging in multiple roles with students and faculty, which I elaborate in some examples that follow.

A common experience was working in my office wearing the "hat" of a graduate assistant and subsequently attending class. Upon arriving at class I would often receive questions from fellow doctoral students (or if I was student teaching, master's students) about topics ranging from internship paperwork to graduation forms to faculty office hours. Initially I was all too happy to oblige my peers and answer questions; however, I soon realized this set a precedent and gave the impression that I was always available as a graduate student despite my set office hours. When I allowed diffuse boundaries, I felt compelled to answer all student, faculty, and administration questions immediately—no matter when, where, or how they were asked. I struggled to set firm boundaries and enforce them, especially at times when I feared responding to one or two requests would lead others to believe I was available at all hours of the day. When the person making a request was a faculty member, there was an extra layer of fear and concern about completing the task due to the power differential. I felt conflicted with obligations both as an employee of the university to assist students and faculty and as an enrolled student to stay focused on my goal of attaining a doctoral degree. Students would ask me to accept their program documents in hallways, classrooms, and even the parking lot instead of following the protocol of turning them in directly to my office or mailbox. Many times I was contacted via my personal cell phone, email, text messages, and social media devices by students who were asking program and class questions. Students would become exasperated when I

failed to respond to their inquiries outside of my graduate assistant office hours, especially on the weekends before my assignments were due on Monday. I felt compelled to help others—that was part of my role—but at the same time I was frustrated with always being on call. I recognized that the more "hats" I owned, the more difficult it became to set limits with faculty, staff, and students—and with myself.

In subsequent semesters I added more roles to my list. I assisted a professor with research that led to coauthoring a publication. I served as a coach to master's students in the clinical skills class and cotaught a couple of master's classes as part of my doctoral program requirement. Serving on my chapter's Chi Sigma Iota executive board was an additional role I assumed during my second year in the program. Furthermore, I had weekly supervision meetings with master's interns in addition to weekly doctoral supervision meetings led by a faculty member. It seemed the more roles I added to my list, the more I experienced the negative effects of the power differential, the phenomenon that sometimes strains relationships between faculty and students. When I was wearing many, if not all, of my "hats," I was simultaneously in a power-down and a power-up role. For example, as a master's supervisor I was placed in an authoritative role with my intern(s) while also serving as a doctoral supervisee and being graded by a faculty member on my abilities to supervise. This was similar to my experience of serving as a coinstructor with a faculty member for a master's-level class. There were many times when master's students would approach me in my teaching role to ask me questions related to my role as a graduate assistant for practicum and internship. Initially it was troublesome to convey to students that while I was engaged in a certain role (e.g., supervisor, teacher, supervisee, graduate assistant) I would limit my responses and responsibilities to those of my present role. Students, and at times faculty, had difficulty accepting my boundary setting attempt, which led to a few unpleasant confrontations. I felt like I was tethered in the middle of a rope and being pulled in opposite directions—another consequence of the power differential.

I decided to consult the *ACA Code of Ethics* (ACA, 2014) and recent literature regarding multiple roles of faculty and students in counseling programs. I assumed that my experiences were not uncommon, but I was confused as to how to navigate the unfamiliar waters of boundary issues with faculty and students—those with whom and for whom I worked. Scarborough et al. (2006) provided sound recommendations that validated my experiences and provided a blueprint for navigating boundary issues between doctoral and master's students. Their article reinforced the reality that doctoral students participate in multiple roles, and they expounded on the effect of the power differential that can easily turn seemingly harmless multiple relationships into sticky wickets.

I experienced some negative consequences when engaged in multiple roles as a doctoral student, but I also reaped benefits. Serving as a gradu-

ate assistant provided me with a wealth of opportunities to work closely with faculty and students and led to mentoring relationships. Proximity to the faculty provided opportunities to foster sound relationships with professors who invited me to coauthor, copresent, and coteach with them. Furthermore, I observed the various roles of faculty members and the tasks they complete to maintain a successful counselor education program. I have gained vast insight into the complexities of supervision and teaching, especially the level of planning and prudent execution required to perform these roles flawlessly. I continue to immerse myself in authorship and presentation opportunities, thanks to the mentorship of several of my professors.

In concluding, I would like to request that more educational opportunities for discussions about multiple relationships and boundary issues be provided for doctoral students in counselor education. Although I learned early on in my master's program and again in my doctoral program to recite the mantra of avoiding potentially harmful dual relationships, reading about a phenomenon is vastly different from experiencing it firsthand. Had I not consulted with faculty, fellow students, ethics codes, and the literature, I would still be at a loss as to how to navigate the murky waters of multiple relationships. Perhaps faculty can build these discussions into classes so that the new generation of counselor educators is prepared to model ethical decision-making behaviors for their future students.

Teaching Students About Boundary Issues

We conclude this chapter with a look at some questions raised by Kristen Dickens:

- What is the responsibility of counselor educators in teaching students about dual relationships and boundary issues?
- How can these issues best be raised and explored in our academic programs?
- How can we prepare students to deal with dual relationship dilemmas in their professional work?

In the ethics courses we teach, we spend considerable time discussing dual and multiple relationships. Our students show a great deal of interest in discussing these issues. Many students have never considered the potential risks of dual relationships, so the discussions serve to increase their awareness of potential ethical dilemmas. We examine dual and multiple relationship standards contained in the codes of ethics of the various professional organizations. We use case vignettes to introduce ethical dilemmas, frequently role-playing a vignette and then discussing possible courses of action. Students are encouraged to think about their

values as these pertain to a host of dual relationship issues. The combination of reading codes and articles, enacting case situations, participating in debates, and being challenged to defend a position typically results in an increased awareness of the pervasiveness of dual relationships. Students begin to develop sensitivity to the subtlety and complexity of the topic.

Through careful attention to program planning and evaluation, students can be helped to increase their sensitivity to dual and multiple relationships that are unethical and harmful. Recommendations for training programs include the following:

- Programs should present literature in which the nature, causes, and consequences of dual relationships are explored.
- The ethical and clinical implications of both sexual and nonsexual dual relationships need to be reflected in virtually all clinical course work and supervision. Real-life dilemmas that surface during students' practica and internships should be addressed in the individual and group supervision sessions that accompany them.
- When programs include a separate ethics course, ample time should be devoted to examination of dual and multiple relationship issues.
- The issue of sexual attraction needs to be addressed, initially in didactic course work and then in supervision throughout students' field experiences.
- In course work containing experiential components, the relevant dual or multiple relationship issues can be specified at the outset and carefully worked through as they occur on a case-by-case basis.
- Institutions and programs within institutions need to develop clear and explicit standards regarding potential dual relationships between students and educators.
- Written, operationally defined procedures need to be developed for avoiding conflicts of interest in monitoring and enforcing institutional standards regarding dual relationships.

Conclusions

In concluding this chapter, we are reminded that actions speak louder than words, and that counselor trainees learn by observing the conduct of their professional role models. Therefore, it behooves counselor educators to model ethical *behavior*, including maintaining clear boundaries and being open to discussing any potential problems that might arise in situations involving multiple roles and relationships. One key to fostering ethical management of dual relationships lies in the *awareness* of counselor educators. If we are unaware of the potential problems, we are likely to find ourselves involved in relationships that are harmful to both student and professor. Another key lies in carefully and systematically teaching our students about the dual relationships and potential dual relationships

they may encounter while they are our students and later as practitioners. If we—and our students—are clearly aware of the potential for conflicts of interest, for exploitation, or for misusing power, these situations are much less likely to occur.

Chapter 6

Issues in Supervision and Consultation

We have seen how subtle and complex boundary issues can emerge in the dyadic relationships between counselor and client and between faculty member and student. These issues can be even more complicated when a relationship is tripartite, as in the relationship among supervisor, supervisee, and client, or among consultant, consultee, and client or client system. In this chapter, we first explore multiple roles and relationships in supervision. Guest contributor L. DiAnne Borders adds a supervisor's personal and thoughtful perspective.

Guest contributors Kathryn L. Henderson and Roxane L. Dufrene share their perspectives on boundary considerations in cases involving supervisee incompetence. Adrianne Trogden addresses several types of boundary concerns for supervisors of addictions counselors and discusses how supervisors can navigate these concerns as they arise. We then look at issues in consultation, with input from guest contributor A. Michael Dougherty.

Supervision

Supervisors play a critical role in helping counselors-in-training and novice counselors understand and manage dual relationships. Students may learn about dual and multiple relationships during their academic course work, but it is during their internships and other field experiences that they come face to face with these issues. The professionals responsible for supervising counselors-in-training must take the initiative in examining dual relationship concerns so that novice practitioners are prepared to respond appropriately when such relationships begin to develop, not only during internships but throughout their professional careers (Slimp & Burian, 1994).

A primary aim of supervision is to create a context in which the supervisee can acquire the experience needed to become an independent professional (G. Corey, Haynes, Moulton, & Muratori, 2010). Effective and ethical supervision involves a fine balance on the supervisor's part: Supervisors are ethically obligated to monitor the quality of care clients are receiving at the same time they are assisting supervisees to become effective counselors. Supervisors have responsibilities to their trainees, and they also have responsibilities to trainees' current clients and to their future clients as well. Protecting client welfare is a supervisor's main responsibility (Association for Counselor Education and Supervision [ACES], 2011).

There is an inherent duality in the supervisory relationship, and the complexity of the supervisory role can create some unique boundary issues. In this section of the chapter, we review some of the literature on these issues and share our own views. These questions will guide our discussion:

- What guidance do codes of ethics and specialty guidelines offer supervisors?
- How prevalent is sexual contact in the supervisory relationship, and what are its effects?
- What are the ethical issues in social and business relationships between supervisors and supervisees?
- How can supervision include exploration of the supervisee's personal issues and remain within ethical boundaries? What is the appropriate balance for supervisors between attending to the professional development and the personal development of the supervisee?
- How can informed consent procedures help to prevent problematic dual and multiple relationships, as well as nonprofessional relationships?
- How can supervisor countertransference best be dealt with in supervision?
- What are the ethical and legal ramifications when the supervisee does not perform competently? How can this create role conflicts for the supervisor?

Ethics Codes and Guidelines

The main purposes of ethical standards for clinical supervision are to provide behavioral guidelines to supervisors, to protect supervisees from undue harm or neglect, and to ensure quality client care (Bernard & Goodyear, 2009). In the *ACA Code of Ethics* (American Counseling Association [ACA], 2014), Section F (Supervision, Training, and Teaching), Standards F.1. through F.6. focus on the various aspects of supervision. In addition, in 2011 the ACES adopted the comprehensive *Best Practices in Clinical Supervision*, which updated their 1993 guidelines for counseling supervisors. *Best Practices in Clinical Supervision* addresses informed consent, goal setting, feedback for supervisees, conducting supervision, the supervisory relationship, diversity and advocacy considerations, documentation,

supervision format, and the supervisory role. These guidelines provide support to supervisors in their work and clarify important aspects of the supervisory process, including multiple roles and relationships:

> The supervisor clearly defines the boundaries of the supervisory relationship and avoids multiple roles or dual relationships with the supervisee that may negatively influence the supervisee or the supervisory relationship. When this is not possible, the supervisor actively manages the multiplicity of roles to prevent harm to the supervisee and maintain objectivity in working with and evaluating the supervisee. (ACES, 2011, 5.c.iii.)

When supervisors have multiple role functions (such as clinical and administrative supervisor, or instructor and supervisor), they strive to minimize potential conflicts and explain expectations and responsibilities associated with each supervisory role to their supervisees. Supervisors have a position of influence with their supervisees. They operate in multiple roles as teacher, mentor, consultant, counselor, sounding board, adviser, administrator, evaluator, and recorder and documenter. Supervisors may serve many different functions during a single supervisory session. They might instruct a supervisee in a clinical approach, act as a consultant on how to intervene with a client, act in a therapeutic way in helping the supervisee with countertransference issues, and give evaluative feedback to the supervisee regarding his or her progress as a counselor. Competent supervisors have a clear understanding of the role in which they are functioning from moment to moment in any given situation, why they are serving in that role, and what they hope to accomplish with the supervisee (G. Corey et al., 2010).

The central issue pertaining to multiple role relationships in the supervisory process is the potential for abuse of power. Like clients in counseling relationships, supervisees are in a vulnerable position and can be harmed by a supervisor who exploits them, takes unfair advantage of the power differential that exists in the context of training, misuses power, or violates boundaries. Effective supervisors are aware of the power differential in the relationship. They discuss with supervisees how this differential can create a potential for exploitation, and they take steps to prevent harm or exploitation. Supervisors strive to minimize the power differential, yet at the same time maintain appropriate authority (ACES, 2011).

The *ACA Code of Ethics* (ACA, 2014) addresses supervisory relationships extensively:

> Counseling supervisors clearly define and maintain ethical professional, personal, and social relationships with their supervisees. Supervisors consider the risks and benefits of extending current supervisory relationships in any form beyond conventional parameters. In extending these boundaries, supervisors take appropriate professional precautions to ensure that judgment is not impaired and that no harm occurs. (Standard F.3.a.)

Finally, the *ACA Code of Ethics* prohibits supervisors "from engaging in supervisory relationships with individuals with whom they have an inability to remain objective" (Standard F.3.d.). The *Code* also states: "Sexual or romantic interactions or relationships with current supervisees are prohibited. This prohibition applies to both in-person and electronic interactions or relationships" (Standard F.3.b.).

ACES (2011) *Best Practices in Clinical Supervision* offers the following guidelines pertaining to ethical consideration of appropriate boundaries in the supervisory relationship:

> d. The supervisor does not compromise the supervisory relationship by engaging in relationships with supervisees that are considered inappropriate.
>
> i. The supervisor does not engage in multiple relationships with supervisees nor with supervisees' significant others.
>
> ii. The supervisor attends to power issues with the supervisee to prevent harmful non-sexual and sexual relationships.
>
> iii. The supervisor explains to the supervisee the appropriate parameters of addressing the supervisee's personal issues in supervision (identifies the issue, helps the supervisee see the clinical implications, works to minimize the detrimental effects in the supervisee's clinical work, contributes to a plan for resolution that does not directly involve the supervisor) and acts accordingly. (7.d.i.–iii.)

Competence Issues for Supervisors

Mental health professionals often are expected to assume the role of clinical supervisor. To carry out these roles ethically and effectively, they must have proper training for their supervisory responsibilities. The skills used in counseling are not necessarily the same as those needed to adequately supervise trainees; thus there is a need for specific training in how to supervise. Supervision is a specialized field that requires specific course work in supervision.

The standards for qualifying to be a clinical supervisor have increased as supervision has come to be recognized as a specialized set of skills and roles, and standards now include formal course work and supervision of one's work with supervisees. Currently, most psychology and counselor education programs offer a course in supervision at the doctoral level, and some programs provide training for supervisors at the master's level (Polanski, 2000). Training in supervision for master's-level counselors is likely to include course work in which students conduct practice sessions to develop their supervisory skills. In doctoral programs, advanced students learn to supervise by supervising master's students, and the doctoral students are in turn supervised by the course instructor. The complexity of managing boundary issues can be challenging when the relationship is tripartite, involving a client, a supervisee, and a supervisor. When relationships involve clients, a supervisee, a novice supervisor, and the supervisor of the supervisor, sorting out the roles and responsibilities can be a daunting task.

Sexual Dual Relationships in Supervision

Of course, if a sexual relationship becomes a part of the supervisory relationship, this confounds the entire process. As previously noted, the *ACA Code of Ethics* (ACA, 2014) prohibits supervisors from engaging in sexual or romantic relationships with supervisees. "This prohibition applies to both in-person and electronic interactions" (Standard F.3.b.). The ethics codes of other professional organizations also take a clear position on sexual intimacies in the supervisory relationship:

> Rehabilitation counselors do not engage in sexual or romantic interactions or relationships with current supervisees or trainees. (Commission on Rehabilitation Counselor Certification, 2010, H.3.b.)
>
> Social workers should not engage in any dual or multiple relationships with supervisees in which there is a risk of exploitation of or potential harm to the supervisee. (National Association of Social Workers, 2008, 3.01.c.)
>
> Marriage and family therapists do not engage in sexual intimacy with students or supervisees during the evaluative or training relationship between the therapist and student or supervisee. If a supervisor engages in sexual activity with a former supervisee, the burden of proof shifts to the supervisor to demonstrate that there has been no exploitation or injury to the supervisee. (American Association for Marriage and Family Therapy, 2012, 4.3.)
>
> Members who provide supervision respect the inherent imbalance of power in supervisory relationships. Thus, they actively monitor and appropriately manage multiple relationships. They refrain from engaging in relationships or activities that increase risk of exploitation, or that may impair the professional judgment of supervisees. Sexual intimacy with students or supervisees is prohibited. (International Association of Marriage and Family Counselors, VII.B., Hendricks, Bradley, Southern, Oliver, & Birdsall, 2011)
>
> Sexual involvement between a faculty member or supervisor and a trainee or student, in those situations in which an abuse of power can occur, often takes advantage of inequalities in the working relationship and may be unethical because:
>
> a. Any treatment of a patient being supervised may be deleteriously affected.
> b. It may damage the trust relationship between teacher and student.
> c. Teachers are important professional role models for their trainees and affect their trainees' future professional behavior. (American Psychiatric Association, 2013b, 4.14.)
>
> Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (American Psychological Association, 2010, 7.07.)

As we have noted in previous chapters, actual prevalence of sexual misconduct is difficult to determine. G. M. Miller and Larrabee (1995) surveyed female ACES members, 6% of whom reported sexual experiences with educators or supervisors during their graduate training. More than half of the sexual contacts were with course instructors, and 28% were with clinical supervisors. A similar ratio was found for sexual advances. Miller and Larrabee caution that findings on perceptions of coercion imply that sexual involvements with supervisees are detrimental. For this reason, sexual relationships between supervisors and supervisees are expressly forbidden.

The Boundary Between Counseling and Supervision

Although supervisors have a responsibility to clarify their roles, it can be particularly difficult to discern where to draw the line between the roles of counselor and supervisor. Confusion over the roles may stem in part from the terminology used in some of the popular models of supervision. For example, Bernard's (1979) discrimination model identifies three supervisor roles as counselor, teacher, and consultant. Yet ethical guidelines state clearly that supervisors should not function as counselors to their supervisees.

ACES (2011) has specific guidelines regarding the function of the supervisor:

> b. The supervisor can clearly describe the purpose of clinical supervision and distinguish it from the counseling process as well as from administrative and program supervision.
>
> i. The supervisor views supervision as an educational and developmental process.
>
> ii. The supervisor is intentional and proactive.
>
> iii. The supervisor is able to make the cognitive shift from thinking like a counselor to thinking like a supervisor.
>
> iv. The supervisor avoids acting as the supervisee's counselor.
>
> v. The supervisor is aware of the power differential that exists between supervisor and supervisee, does not let it threaten supervisory trust, and makes power issues transparent.
>
> vi. The supervisor understands, accepts, and acts on her/his role as an evaluator and professional gatekeeper, continually monitoring and evaluating the supervisee's practice of counseling to protect and safeguard the well-being of clients.
>
> vii. The supervisor encourages supervisee autonomy as appropriate.
>
> viii. The supervisor can clearly articulate her/his role as supervisor, including teacher, counselor, consultant, mentor, and evaluator.
>
> ix. The supervisor practices and promotes professional boundaries in supervision, thereby acting as a role model to the supervisee.
>
> x. The supervisor demonstrates professionalism in an effort to encourage the supervisee to exhibit similar behavior. (11.b.i.–x.)

Although supervisors have the responsibility to help supervisees understand how their personal issues may interfere with working effectively with clients, it is not appropriate for supervisors to change the supervisory relationship into a counseling relationship. The *ACA Code of Ethics* (ACA, 2014) is clear on this issue:

> If supervisees request counseling, the supervisor assists the supervisee in identifying appropriate services. Supervisors do not provide counseling services to supervisees. Supervisors address interpersonal competencies in terms of the impact of these issues on clients, the supervisory relationship, and professional functioning. (Standard F.6.c.)

Several of the focus questions that we asked at the beginning of this chapter are so interrelated that they cannot be discussed separately. For instance, how can supervision include exploration of the supervisee's personal issues as well as cases without crossing the line into becoming a counseling relationship? The following vignette illustrates how this issue may arise:

> Andrew is a counselor educator and supervisor who regularly teaches an internship seminar. Andrew makes it clear to students at the initial class meeting that he conducts his seminar using a group supervision format that focuses on the counselor as a person. He informs his students that "the main emphasis will be on your own dynamics and reactions to your clients—not on an analysis of your clients, counseling skills and techniques, or case management strategies. Of course, you will learn various alternatives for working with your clients, but our primary concern will be on how your attitudes and behaviors may be influencing your clients. Thus you will be expected to examine your needs, motivations, and most of all your potential sources of countertransference in these group supervision sessions."
>
> Andrew's chairperson questions the appropriateness of his style of teaching the seminar. Other instructors focus on teaching specific skills and interventions and do a great deal of case management work. The chairperson thinks that Andrew is opening himself to the possibility of blurring his role as an educator by focusing on the personal dimensions of his supervisees. She suggests that he recommend to his students that they seek personal counseling apart from the program and that he focus his course more on skill development.
>
> In his defense, Andrew claims that he is not conducting group therapy; rather, he is asking his students to look at how their own dynamics influence their interventions with their clients. He deals with personal problems of his supervisees only to the extent that these problems appear to be influencing their work. He sees it as his job to help supervisees become aware of the ways their personal dynamics are affecting their clients.

- Do you think Andrew's chairperson has legitimate reasons for concern that he is getting involved as both educator and therapist with his supervisees?
- What do you think of Andrew's approach to group supervision?
- What is the appropriate balance between teaching supervisees about their own dynamics and the dynamics of their clients?
- What is the balance between focusing on supervisee self-awareness and teaching skills?
- What are some potential benefits and risks to Andrew's supervisees?
- Would you want to be a student in the class?

It can be difficult to determine when a supervisory relationship has become a counseling relationship. When supervisees have personal problems, supervisors want to address those problems if they are affecting the supervisee's work. However, because the primary goal of supervision is to protect the welfare of the client, the personal growth of the supervisee cannot become the primary focus of supervision. When supervisors agree to counsel their supervisees, these dual relationships model dangerously inappropriate behavior for supervisees, who may later perpetuate the behavior when they become supervisors themselves.

On the other hand, if the supervisor avoids the counselor role and instead recommends personal counseling for a supervisee, this may infuse an emotionally charged issue into the relationship. The supervisee may feel threatened and believe he or she has been judged to be incompetent. The supervisory relationship could become strained, and the supervisee might be less open about his or her own experiencing in discussing cases with the supervisor.

- If you were a supervisor faced with the need to recommend counseling for a supervisee, how might you go about it?
- What factors might you consider in making your recommendation, and what might you tell the supervisee?
- If you were a supervisee, how would you react if your supervisor made such a recommendation to you?
- Might this change the nature of the supervisory relationship from your perspective?

From our perspective, effective supervision includes a focus on the impact of the counselor on the counseling process. When supervision focuses exclusively on client cases or problem-solving strategies for working with clients, some opportunities for positive experiences are lost. The results of a study by Sumerel and Borders (1996) indicated that a supervisor who is open to discussing personal issues with supervisees in an appropriate manner does not necessarily affect the supervisor–supervisee relationship

negatively. Ladany and Friedlander (1995) found that the stronger the emotional bond between supervisor and supervisee, the less role conflict was experienced by the supervisee. Usher and Borders (1993) found that counselors preferred a supervisor who is collegial and relationship oriented over one who is task oriented.

Supervision can be useful in helping students become aware of personal limitations or unresolved problems that intrude into effective helping. However, there is a difference between helping students identify and clarify those concerns they need to explore and converting supervision into an in-depth personal therapy session. For instance, if a student becomes aware of an unresolved issue with his mother that is being played out in his counseling sessions with “motherly” women, it is appropriate to focus on how his personal limitations are blocking effective counseling, but it is not appropriate to abandon the supervisory focus for a therapy experience that delves into the trainee’s unresolved personal problem. In such cases, students should be encouraged to get the therapy they need for themselves personally and professionally.

Distinguishing the appropriate boundary between supervision and counseling can be difficult.

- If you are a counseling supervisor, where do you stand on these issues?
- Do you believe that the supervisory and counseling roles are separable?
- Or do you think that some role blending is inevitable?
- How might you defend your position if a colleague challenged your views?

If you are a graduate student working under supervision, or a counselor working under supervision toward your licensure or certification, do you believe supervisory and counseling roles are separable?

- Where do you want your supervisor to draw the line in dealing with any personal concerns you may be facing?

Social and Business Relationships With Supervisees

Another boundary issue concerns social relationships. It is inevitable that supervisors will encounter trainees in social settings and at community activities. Hararr, VandeCreek, and Knapp (1990) suggest that a supervisor need not avoid supervisees on such occasions unless the supervisor believes the professional relationship will be compromised. However, they caution against attempting to supervise relatives, spouses, friends, former clients, or others with whom the supervisor might find it difficult to be candid about performance.

Some supervisors may be inclined to relax the boundaries as supervisees near completion of their training programs or their postmaster’s supervision. At this stage, interactions with their supervisors often take on

a collegial tone, and supervision becomes more consultative in nature. The social relationships that might develop out of a sense of collegiality and common interests may help to mark the supervisee's transition to becoming a professional peer. Nonetheless, Slimp and Burian (1994) note that the supervisor is still in a position to evaluate supervisees and to recommend them for future employment and that a social relationship could compromise the supervisor's ability to make an objective evaluation. Yet some relaxing of boundaries may be both inevitable and appropriate. Bernard and Goodyear (2009) take the position that it is necessary to differentiate between multiple relationships that abuse power and may exploit or harm supervisees and those that occur within the "positive context of a maturing professional relationship" (p. 62).

There is a difference between client–counselor and supervisee–supervisor relationships in considering postprofessional relationships. Some have argued that "once a client, always a client," but that claim is not made about supervisees. Our supervisees evolve into our professional colleagues. It is important to remember, though, that the perception of change in role relationships does not necessarily accompany the fact of the change. The end of formal supervision does not automatically mean that a supervisee perceives that he or she is now on equal footing with the former supervisor.

Regarding business relationships with supervisees, Slimp and Burian (1994) believe it is not uncommon for interns in field placements to be hired as staff members' employees. They cite examples ranging from babysitting to assisting staff members in research or consulting activities and note that it could be quite difficult for an intern to resist staff members' requests for paid services. Such situations place the supervisee in double jeopardy, and if the babysitting, research, or consulting activities do not go well, the negative consequences are compounded. Trust, respect, and a sense of safety are damaged; the reputations of both individuals may be diminished if the problems come to light; the quality of training is likely to be affected; and the staff member's evaluation of the supervisee will almost certainly be influenced. In addition, others within the training agency are affected because fellow interns may feel left out of what they perceive to be preferential treatment, and staff members may become fractionalized as they develop opinions about the relationship. Such dual relationships have implications for the profession as well because supervisees who learn that such relationships are acceptable may engage in them with their clients. For all these reasons, Slimp and Burian recommended that these types of relationships be avoided.

Decision-Making Models for Supervisors

Several writers have offered models to assist supervisors in working though the supervision process with their boundaries intact. Wise, Lowery,

and Silverglade (1989) suggested a stage-oriented approach. In the *self focus* stage, supervisees begin to see clients but lack knowledge and experience. Supervision is most helpful when it concentrates on skill development, clarifying concerns and providing structure. In the *client focus* stage, supervisees have increased interaction with clients, and they typically increase their initiative and become less dependent on their supervisors. The supervisor continues to concentrate on skill development and case conceptualization. Personal counseling might be recommended only if the supervisee remains too dependent on the supervisor or is not making adequate progress because of personal issues. In the *interpersonal focus* stage, supervisees become more comfortable with their skills and shift their focus from issues of competence to issues of self-awareness. This may be the most appropriate time to recommend personal counseling to promote supervisee openness and awareness. In the final *professional focus* stage, supervisees have begun to develop a therapeutic personality and a sense of professional identity. A consultation model of supervision is most appropriate, and personal counseling should be recommended only to deal with "blind spots" in specific areas or life stressors that are impeding performance.

Informed Consent in Supervision

Informed consent regarding supervision is as essential as informed consent in counseling. It is beneficial to discuss the rights of supervisees from the beginning of the supervisory relationship in much the same way as the rights of clients are addressed early in the therapy process. One way to clarify the multiple roles of supervisors is to provide a written informed consent document that can be given to all supervisees at the outset of the relationship (Sutter, McPherson, & Geeseman, 2002). Such contracts may not be legally binding, but they do serve to inform the supervisee of expectations and responsibilities of both parties in the supervisory relationship and benefit both supervisor and supervisee.

If there is a frank discussion at the beginning about the mutual responsibilities of supervisors and supervisees, conflicts are less likely to develop at a later time. As a part of the informed consent discussion, supervisors can explain that supervision is a complex process and that supervisors are required to function in multiple roles. They can take this opportunity to be clear from the outset that personal issues might be activated in supervision, and that if these issues affect performance, the supervisee will be asked to work them through with another professional (Bernard & Goodyear, 2009). The risks and safeguards of multiple relationships can be explored. This not only can lead to more effective supervision sessions, but it can also model the importance of informed consent in therapy. Supervisees learn firsthand how to convey information to their clients that will enable them to become active partners in the therapeutic process.

Ladany and Friedlander (1995) found that supervisees experienced less role ambiguity when their supervisors made expectations clear. McCarthy and colleagues (1995) contend that informed consent should be clearly articulated through written documents and a discussion between supervisor and supervisee. Accountability can be increased with a written contractual agreement for supervision. When expectations are discussed and clarified from the beginning of a supervisory relationship, the relationship is likely to be enhanced and quality client care will be promoted. McCarthy and her colleagues recommend that the contract include statements concerning ethical and legal parameters of the supervisor–supervisee relationship. Topics should include dual relationship issues, structuring of the supervisory relationship, limits to confidentiality, and professional guidelines for ethical treatment of clients.

Countertransference Issues

Supervisor countertransference is bound to occur in some supervisory relationships when supervisors have intense reactions to certain supervisees. We hope supervisors will monitor their countertransference and seek their own supervision, or at least consult regularly with colleagues, when these issues arise. To help ensure that evaluation remains fair, Bernard and Goodyear (2009) recommend getting a second opinion about a supervisee's abilities.

Countertransference does not have to be viewed negatively. Indeed, by monitoring our countertransference in the supervisory process, we can learn some important lessons about supervisees. Our reactions to supervisees can tell us something about them as well as about ourselves. We suggest that supervisor countertransference be dealt with in a manner similar to therapist countertransference. It is important to be aware of our countertransference reactions. It is crucial that we understand our needs and how they may be triggered by certain supervisee behaviors. This is especially true when a supervisor is sexually attracted to a certain type of supervisee. It is crucial that supervisors do not exploit supervisees for the purpose of satisfying their needs and that they do not misuse their power over supervisees. When a supervisor has unmet needs that interfere with effective supervision, the supervisee is placed in a difficult position. As supervisors, it is important that we recognize our countertransference issues and seek consultation. We also have an obligation to take further measures to protect our supervisees if we are unable to successfully resolve our issues. These measures might include seeking personal therapy, referring the supervisee to another supervisor, or inviting a colleague to cosupervise sessions if the supervisee agrees to this.

Supervisee Incompetence: Ethical and Legal Considerations

Supervisors are both ethically and legally responsible for the actions of those they are supervising. For example, if a client of a supervisee

commits suicide, the supervisor is likely to be more vulnerable than the supervisee from a legal standpoint. The reality of the fact that supervisors are responsible for all of the cases of their supervisees does place special pressures on the supervisor that could create a conflict. If the supervisor becomes aware that the supervisee lacks basic relationship skills or lacks personal maturity, what is the supervisor to do? Is it appropriate to bring this to the attention of the faculty? A determination must be made regarding whether the supervisee is personally qualified to remain in the training program. The legal ramifications of the supervisor's responsibilities when the supervisee is not functioning competently underscore the importance of clearly defining the nature of the supervisory relationship from the outset. Students should know about the consequences of not competently fulfilling their contracts. To be sure, supervisors have a duty to do what is in the best interest of the supervisee, yet they also have a responsibility to the welfare of the clients who are being seen by the supervisee. As gatekeepers of the profession, supervisors cannot ethically ignore dealing with supervisees who cannot competently carry out their training role because of some personal limitations. This matter deserves full discussion at the outset of the supervisory relationship.

Monitoring the competency of students in training has long been viewed as an essential component in training programs. In addition to evaluating a supervisee's academic ability, knowledge, and clinical skills, it is essential to identify and evaluate a supervisee's personal characteristics, interpersonal behaviors, and professional behaviors that will likely influence his or her ability to effectively deliver mental health services.

On the matter of evaluation, ACES (2011) offers specific guidelines:

a. The supervisor understands that evaluation is fundamental to supervision and accepts his/her evaluation responsibilities. (9.a.)
b. The supervisor clearly communicates the evaluation plan to the supervisee. (9.b.)
c. The supervisor encourages ongoing supervisee self-evaluation. (9.c.)
d. The supervisor takes appropriate steps when remediation is necessary. (9.d.)

It is critical that supervisees do not hear from their supervisors that their performance is substandard when it is too late for them to take corrective measures. Supervisors have an obligation to provide their supervisees with regular, specific, and ongoing feedback. If there are problems regarding supervisees' performance, they must be given opportunities to take remedial steps to correct the problems. Of course, due process is essential, and dismissal from a training program should be the last resort after other interventions have failed to produce any change in supervisees who exhibit deficiencies.

A Contributor's Perspective

Some boundaries in the supervisory relationship are clearly demarcated: Supervisors should not enter into sexual or romantic relationships with their supervisees, supervision should not be converted into therapy, and business relationships with supervisees should be avoided. DiAnne Borders offers a thoughtful personal perspective on some more subtle boundary issues in supervision.

Subtle Boundary Issues in Supervision

L. DiAnne Borders

To the best of my knowledge, I have not violated the two ethical "rules" regarding dual relationships (ACA, 2014; ACES, 1993). I have not knowingly taken the counselor role with a supervisee, although I've explored personal issues affecting supervisees' work many times, and I've never had an intimate or sexual relationship with a supervisee. However, I have had a dual relationship with all of my supervisees. In fact, I have had triple and quadruple relationships with some of them.

When I was department chair, I hired, evaluated, supervised, and rehired (or not) all the graduate assistants in the department, so I was the employer of some of my supervisees. For some, I am the chair of their doctoral and dissertation committees. For these and others, I serve in mentoring roles that create dual relationships (e.g., coauthor, copresenter). In addition, a few were my son's babysitter at one time or another (when I was in a real pinch). All have heard numerous stories about my son, and a few have been valued consultants regarding their areas of expertise related to his development. At the least, most of my supervisees are students in my classes. Usually these multiple relationships are not particularly problematic or particularly challenging, at least from my perspective. At other times, I have had to give deliberate thought to putting boundaries around my varied roles with a supervisee, and I have even ended a role with a few.

At times, then, I've concluded that I was in a dual role that was affecting my ability to provide adequate supervision, thus overstepping a guideline in our profession's ethics code and best practice guidelines that states

> The supervisor clearly defines the boundaries of the supervisory relationship and avoids multiple roles or dual relationships with the supervisee that may negatively influence the supervisee or the supervisory relationship. When this is not possible, the supervisor actively manages the multiplicity of roles to prevent harm to the supervisee and maintain objectivity in working with and evaluating the supervisee. (ACES, 2011, 5.c.iii.)

But how am I to know when I've crossed the line? How does any supervisor accurately evaluate the impact of a dual role on a supervisory relationship? In

particular, how does a supervisor evaluate the situation from the *supervisee's* perspective? The more subtle boundary issues in supervision may go unnoticed whether they have positive or negative effects.

Clearly my supervision is colored by my knowledge about my supervisees from our other interactions. On the positive side, I sometimes can predict those situations in which the student will need extra help, and often I already have some sense of how feedback is most easily heard. In addition, the context of the supervisory relationship frequently provides the needed vehicle for bringing to light issues that I need to address with a student. There are negative consequences also, however. For example, I remember one instance when I did not push an observation as far as I could (or should) have because I thought it would be too much on top of the feedback I'd just given regarding the supervisee's dissertation the day before. She graduated without the assumed benefit of this particular feedback. Then there was the new supervisee who previously had been assigned as my research assistant. The supervisee had not fulfilled those duties satisfactorily, and I had not made the desired progress on a research project as a result. In our first supervision session, then, we had to address directly our leftover feelings (e.g., my irritation, the supervisee's regret as well as feelings that I had not explained the tasks clearly enough) before we could proceed productively. And did I behave differently with a doctoral practicum supervisee because I hoped the supervisee would ask me to chair his doctoral and dissertation committee?

My broader knowledge of and interactions with these students also often brings to light how our personal and interpersonal dynamics can and do affect our supervisory work together. In one supervisory session, I realized this was the third time that week that I had urged a supervisee to urge his client to break free of constraints, act outside the norm, and explore an untapped aspect of self. Was this perhaps a theme of my own rather than some coincidence of supervisee (or client) issues? And there are those times that I realize I am allowing too much supervision time to be spent in philosophical discussions that the supervisee and I enjoy, or when I am aware of how much I rely on a supervisee's sense of humor (being overly prone to seriousness myself), both in and outside of our supervision sessions. With other supervisees, I must refuse to stand on the pedestal, even though they need me (and any other supervisor) to be there, but wonder if I might so quickly recognize the dynamics and respond the same way if it was one of those times in my life when I needed to be appreciated or admired. Such dynamics challenge the boundaries of the supervisory relationship, even though they also may enrich it at times. Nevertheless, I struggle with how to be human without being overly familiar or inappropriately self-revealing.

It could be easy to become good friends with many of my supervisees. We have similar interests, they are often good cooks, and we have some understanding of each other's professional pressures and goals. Over the

years, however, I have learned to be cautious. Social relationships and friendships tend to interfere with two priorities: to be consistent and fair with all supervisees, and to feel free to say whatever I need to say in supervision. The more relaxed atmosphere created by sharing a good meal or another social event seems to blur the boundaries for both supervisor and supervisee. I find it somewhat uncomfortable to confront a supervisee shortly after we have been in each other's homes, and I have seen confusion on a supervisee's face when I did confront. I have heard supervisees, my own and others, wonder what academic benefits a peer might be getting because of his or her social relationship with a supervisor. In addition, certainly my past experiences on the ACA Ethics Committee have made me more sensitive to the potential problems in even well-intentioned acts of friendship. As cochair of the Ethics Committee, I learned details of clear abuses of power, often rationalized as a "natural" outgrowth of the multiple roles a counselor educator and supervisor plays with students. In other cases, I tried to sort out what seemed to be a supervisee's unfortunate misunderstandings of a supervisor's benign overtures of friendship and support.

As a result, I more and more have limited my social encounters with students to officially sanctioned events (e.g., departmental picnics, conference receptions, graduation celebrations) and more frequently address these issues up front with supervisees (and students in similar roles). In particular, I ask students to share their perspectives on our dual roles and relationships and make clear that I don't assume their perspective will be the same as mine. As needed, we can make a plan together that respects their feelings as well as mine. As the ethical guidelines and supervision best practices make clear, it is always *my* responsibility to maintain appropriate boundaries and monitor dual or multiple roles with supervisees and students. Given the power differential, which exists in whatever relationships we have with students, supervisees are at a great disadvantage in terms of bringing to my attention that they feel uncomfortable or unsure about such issues.

Clearly, such issues need to be addressed in supervisor training programs. In fact, doctoral students often encounter boundary and multiple role issues *before* they graduate. "I just realized," a note from one doctoral student indicated, "that I'm in the same class with one of my supervisees. Do we need to do something about this?" The ACES (2011) *Best Practices in Clinical Supervision* states, "If the supervisor is a doctoral student, the doctoral student's supervisor avoids pairings of supervisor–supervisee that would pose a conflict of interest" (7.d.iv.). Recognition of potential problems, then, is a critical first step, to be followed by discussions of how to handle the situation, thus providing an important learning opportunity for supervisees and their peers. I can have hope that they will recognize similar dilemmas in the future.

The many gray areas and potential hazards also suggest to me that we supervisors always have need of supervision or consultation regarding

our work with supervisees. The need will vary not only by supervisee but also by the relevant circumstances in a supervisor's life. We are more vulnerable in terms of our own needs and motivations at various points in time. Just as we seek additional monitoring of our work with clients during these times, we also must consider how our circumstances and personalities may affect the supervision process.

Interestingly, there is very little research on the gray areas and more subtle issues regarding boundaries and multiple roles presented in this chapter. Even less attention has been given to the *supervisor's* dynamics alluded to here. This may be because typically the supervisors are conducting the research or because the relevant variables are difficult to identify, let alone operationalize. We should not continue to pretend, however, that we become objective, neutral supervisors simply by having earned a diploma.

Although I have written primarily about my boundary and role confusion in an academic setting, I would not be surprised to find similar issues in supervisory relationships in employment settings and for private practitioners working with counselor licensure applicants. The ACES (2011) *Best Practices in Clinical Supervision*, designed to be applicable across academic and practice settings, provides a sound beginning for assessing these situations and determining how to respond so that we can avoid problematic boundary violations and, when necessary, appropriately negotiate how to handle such situations. (For a more complete discussion of ethical issues in supervision, see Borders & Brown, 2005.)

A Contributor's Perspective

In the preceding section, we learned about boundary and role issues from a supervisor and counselor educator's perspective. In the following section, Kathryn L. Henderson and Roxane L. Dufrene address the challenges of dealing with supervisee incompetence.

Boundary Issues With Supervisee Incompetence

Kathryn L. Henderson and Roxane L. Dufrene

At times, supervisors work with supervisees who are experiencing professional challenges. In such situations, boundary issues take an important role within the supervisory dyad and within the larger system where supervisees are struggling. Traditionally, supervisees who demonstrate problems with professional competence have been referred to as impaired (Elman & Forrest, 2007). The *ACA Code of Ethics* (ACA, 2014) requires that supervisees who are experiencing problems with professional competence be remediated. Supervisors often hold a central role in facilitating remediation with supervisees. A helpful perspective is to focus on the professional competence required of supervisees rather than on the reasons for supervisee incompetence.

Awareness of possible boundary issues is beneficial when remediating supervisees. A topic for reflection related to boundaries is the supervisor's stage of development. Increasing self-awareness of supervisors' professional development can assist supervisors to understand how they are making decisions and their responses to supervisees. For example, a supervisor might take too much responsibility for a supervisee's circumstances. In this scenario, supervisors might need to define what their responsibility is, where their responsibility ends, and where the supervisee's responsibility begins. A question that supervisors might reflect on is, "Who is doing more work in supervision, the supervisee or the supervisor?"

Professionals who provide supervision often are internally balancing multiple roles of supervisor, counselor, and evaluator. When working with supervisees who have challenges with professional competence, the role of evaluator comes to the forefront. Providing supervisees with ongoing, informal, and formative feedback is a traditional responsibility of supervisors. During remediation, the feedback process should become more formal and structured, and supervisors should actively monitor the supervisee's competence. Specific areas of professional, personal, and interpersonal growth should be identified for the supervisee to display in a certain time frame, such as a semester (Dufrene & Henderson, 2009; Kress & Protivnak, 2009). The supervisor's role is to evaluate whether or not the supervisee is able to demonstrate growth, with evaluation occurring in each supervision session. Discussing the process of how evaluation will unfold during supervision encourages transparency within the supervision dyad. When an open and ongoing dialogue is established regarding the evaluative role of the supervisor, the supervisee will have a clearer idea of what to expect during remediation, which can alleviate unspoken fears or concerns.

Similar to practicing clear boundaries with clients, it is vital that supervisors model clear boundaries with supervisees. As with clients, supervisors need to practice empathy with supervisees, separating their own personal reactions to supervisees and remaining in a professionally neutral role. At times supervisors may dislike the behaviors that supervisees exhibit or may feel that supervisees are personally attacking them. For instance, a supervisee may blame the supervisor for the supervisee's failures. In such cases, a supervisor may prefer not to work with a supervisee needing remediation or may ignore unprofessional behaviors to avoid an unpleasant confrontation. Adopting a professionally neutral role can assist with avoiding personal reactions that might impede the supervisor's ability to work productively in challenging scenarios. Consider the scenario in which a supervisee has experienced a divorce. The supervisor can empathize with the supervisee's loss but not accept that loss as a rationale for the supervisee's lack of clinical competence and failure to submit the necessary audio or video recordings of counseling sessions. The supervisee might feel angry and defensive and question the decision to uphold the

requirements. Using a professionally neutral lens to reflect on the circumstances can assist the supervisor in separating personal responses from professional obligations.

A phenomenon related to boundary issues is the supervisor's responses to the emotionality that may be displayed by a supervisee. A supervisee's personal resistance or refusal to comply with supervision requirements can be manifested in emotional reactions, which can range from anger and hostility to fear, sadness, and crying. The supervisor needs to be cautious and avoid responding to emotionality by taking on the counselor role. If the supervisor processes these feelings with the supervisee, this can distract from the supervision session's goal of addressing professional competency and remediation.

Supervisors should be aware that boundaries differ with respect to how counselors respond to clients who display elevated emotionality versus how supervisors respond to supervisees who display elevated emotionality. The *ACA Code of Ethics* (ACA, 2014) instructs supervisors not to provide personal counseling to supervisees. When elevated emotionality is a factor during supervision, keeping a professional focus is imperative. A perspective to explore with supervisees is how emotions are affecting supervision. Many times emotions interfere with progress during supervision. Supervisors also can explore how these emotions are affecting supervisees' competency as counselors-in-training. If supervisees are unable to effectively and appropriately discuss their emotions, how to manage emotions as a competent professional might be added as an area for remediation. An option is to recommend personal counseling for supervisees to address the personal issues triggering the elevated emotionality.

Elevated emotionality of supervisees can easily become a distracter during supervision. Distracter topics initiated by supervisees emerge as patterns that take time away from the goals of supervision. Distracter topics include talking about other students and supervisors or counseling program concerns not related to supervision. Other distracters include supervisees blaming someone else (such as an administrator, other supervisors, or even clients) for the challenges they are experiencing. Supervisors should aim to establish clear boundaries with supervisees regarding topics that are not appropriate for supervision. Supervisors are responsible for keeping the topic of discussion on a track of supervisee professional development. Supervisors can work to help supervisees become aware of their role in problems and accept personal responsibility. Distracter topics also can be personal issues the supervisee is experiencing, such as recently moving into a new house, the death of a family member, or other personal changes. Supervisees might blame their personal events for the professional competency challenges they are demonstrating. Options for consideration include recommending personal counseling or arranging with the supervisee to withdraw from clinical practice for a temporary period or take a leave of absence.

Although supervision typically occurs in a dyad, it also occurs within a larger system, such as a counseling program in a university. Supervisors are generally the professionals who directly work with supervisees, but other professionals involved during remediation could include other faculty, agency administrators, university administrators, and university attorneys. Clear communication and problem-solving abilities with all professionals are necessary. Skilled supervisors who are self-aware of professional and personal issues can assist in transparent communication. Supervisors are encouraged to take note of how the professionals involved handle their roles. Covert interpersonal dynamics can increase or decrease because the many professionals involved may have varied perspectives. Boundary issues that may arise can be embedded in the context of more global professional roles within the system, which affects interpersonal interactions with all involved. Possible boundary issues of each professional can affect a supervisor's experiences with a supervisee. For example, boundary issues might include other professionals' alignment with a supervisee out of fear of litigation, lack of understanding of how to deal with a supervisee, or resistance to acknowledging a supervisee's competency challenges. Knowledge of what others do professionally will assist supervisors in understanding and managing boundary issues with the involved professionals as well as with the supervisee.

Within a system perspective, responses to supervisees who have challenges with professional competence should be proportionate to the magnitude of the problem. Because decisions about remediation ultimately fall either to university counseling programs or to licensing boards, there may be differences between professionals' views of remediation and the supervisees needing remediation. A novice supervisor, such as a junior faculty member, may be the only supervisor working with a supervisee who has competency problems. When do the problems become a significant enough concern to inform all faculty members in the counseling program? Having routine opportunities to inform all faculty members of supervisees with competency challenges can offer support and collaboration for supervisors. A standing agenda item regarding supervisees can be added to regular faculty or staff meetings and included in remediation policies. Open discussion among faculty about supervisee challenges contributes to the system being responsible for the supervisee, rather than the supervisor alone having to take the responsibility.

Boundary issues can be a contributing concern within the larger system and the supervisory dyad. For example, if a supervisor denies a supervisee request, the supervisee may approach other faculty or the supervisor's superior with the same request—without notifying the supervisor first. Within the context of a graduate counseling program, supervisees might go to the dean of the college or provost of the university with their complaints, without letting the supervisor know. Supervisors are encouraged to set the expectation that supervisee competency concerns can occur and

will be dealt with in supervision. Also, supervisors may consider whether it would be helpful to identify to their superiors the supervisees who are being remediated.

Consultation with legal counsel and the administration is important to ensure compliance with agency or university policies and to prevent possible conflicts with existing policies and procedures. Another good method for monitoring boundary issues is consulting with colleagues who are outside the current system. Professional collaboration may provide all professionals involved with needed support. Supervisors should inform all individuals involved, including supervisees, that collaboration among professionals will occur.

Although many boundary issues may be related to remediation, supervisory relationships can serve as a catalyst for positive reinforcement and role modeling of professional competencies that supervisees have been unable to exhibit. Activities that could improve professional boundaries include orienting all professionals involved to the remedial needs of supervisees, fostering a positive outlook toward remediation, and fostering a learning environment. When supervisors are clear that the focus of remediation is to objectively document competency concerns and monitor progress, they are better able to maintain clear boundaries with supervisees.

Supervision of Addictions Counselors

The specialized field of addictions counseling provides a unique set of boundary concerns for supervisors and addictions counselors to consider so they can successfully navigate the supervision process. Many addictions counselor supervisors find themselves involved in multiple roles, particularly within treatment facilities, and often struggle to maintain appropriate boundaries with supervisees.

A Contributor's Perspective

In the following piece, Adrianne Trogden, an addictions counselor and supervisor, shares her perspective on boundary issues in the supervision of addictions counselors.

Boundary Issues in Supervision of Addictions Counselors

Adrianne Trogden

Most of the ethics codes of the various mental health professions caution about potential problems involved with dual and multiple relationships with clients as well as with supervisees. Dual relationships are commonplace for addictions counselor supervisors, and it falls on the shoulders of the supervisor to be vigilant in managing these relationships appropriately.

Just as the counselor has the responsibility of maintaining appropriate boundaries with his or her clients, the supervisor is responsible for upholding boundaries in the supervision relationship.

Many addictions clinical supervisors are also administrative supervisors of their supervisees, which pushes the supervision role beyond counseling skills to job performance. In these situations, supervisees may feel uncomfortable talking about struggles they are having for fear of losing their job. It also may be tricky for the supervisor to manage both "hats." As the supervisor, it is necessary to set boundaries and define the supervision relationship to best serve the supervisee's needs as well as to protect both parties within the relationship. It is important to clearly delineate for both parties what topics are discussed in clinical supervision sessions and how that is different from topics appropriate for administrative supervision sessions.

Ongoing evaluation of the supervision process and role dynamics is beneficial to the smooth navigation of the relationship. The informed consent process, conducted at the beginning of and throughout the supervision relationship, is a good place to address boundaries of the relationship and to establish a firm foundation on which to build a strong supervision experience for both supervisor and supervisee. Many supervisors, including myself, have found a written contract to be useful in helping to set initial parameters of the relationship that include expertise of supervisor, cost of supervision, structure of sessions, cancellation policy, limits of supervision relationship, length of supervision relationship, how impairment is handled, number of sessions required, and evaluation process. A written contract is particularly helpful in defining the lines between clinical and administrative supervision.

In many substance abuse treatment facilities, former clients become counselors after completion of treatment (Culbreth, 1999). Therefore, a supervisor immediately has a dual relationship with a supervisee if he or she was a former client. When a former client becomes a supervisee, it is important to evaluate the power differentials. A supervisor–supervisee relationship has an inherent power differential due to the evaluative role of the supervisor. When a former client moves from the role of client into the role of counselor or supervisee, compounding factors must be discussed and evaluated. How is the transition from client to counselor navigated? How is the supervision relationship different from the counseling relationship? What boundaries need to shift or change as a result? What impact does this change have on the supervision relationship? How is relapse handled? These questions are further compounded when one person serves as both clinical and administrative supervisor of an individual. There are many benefits to having recovering counselors working in a treatment facility—they bring unique insights to the counseling relationship, such as an understanding of the culture of addiction, the ability to be a role model to clients, empathy for suffering, and insight related to 12-step fellowship

involvement (McGovern & Armstrong, 1987; White, 2000)—but these dual relationships present unique problems as well.

In 2009, about 43% of addictions counselors and 37% of addictions counselor supervisors were in recovery, based on self-reports (Eby, Burk, & Birkelbach, 2009). Counselors and supervisors who identify themselves as "recovering" are typically indicating that they have a personal history of addiction and are currently out of active addiction and living an addiction-free lifestyle. Many recovering counselors and supervisors maintain a connection to recovery-centered activities, such as attending 12-step meetings, self-help groups, counseling, sponsorship, and volunteer activities. Nonrecovering persons are those who deny a personal history of addiction. For supervisors who are personally recovering or working with recovering supervisees, managing recovery is a topic to be addressed in supervision. Many recovering persons attend recovery-centered activities to maintain long-term recovery, so there is strong potential for recovering supervisors and supervisees to end up at the same activities. Recovery-related activities are intended for the participants to work on their own personal recovery and present a potential for a dual relationship when a supervisor and supervisee jointly attend. The professional supervision relationship may move unintentionally into a peer relationship if boundaries are not established. Discussing how to handle these types of situations in supervision meetings can help prevent uncomfortable community encounters and mitigate damage to the supervision relationship.

In addition, self-disclosure may become an issue for recovering supervisors or supervisees because recovering counselors have a greater tendency to use subjective personal recovery experiences along with theory and training to treat clients (Blum & Roman, 1985; White, 2000). This also may become an issue in the supervision relationship because substance abuse counselors are less likely to have had formal training. Their learning comes from the supervision experience much more than from formal education (Culbreth, 1999; Saarnio, 2010), and supervisors are primarily responsible for imparting theory and education to substance abuse counselor supervisees. Supervisors have an opportunity to model appropriate use of self-disclosure within supervision sessions to teach supervisees how to use self-disclosure appropriately with their clients. Supervisors need to teach supervisees to use theory as well as personal recovery experiences to treat clients.

Discussions surrounding potential relapse or impairment are important as well. What happens if the supervisor or supervisee relapses, and how is this handled in terms of supervision? Many substance abuse treatment programs expect recovering employees to maintain abstinence, and disciplinary action is taken if a relapse occurs. Conversations in supervision sessions about how relapse will be handled can mitigate damage to the relationship and set clear guidelines or boundaries for the relationship. The supervisor in this situation may be tempted to provide some type of therapy or

intervention to the relapsing supervisee. Even though supervision does incorporate the reactions and countertransference concerns of the supervisee, the supervisor should not cross the boundary into providing therapy to the supervisee. The supervisor can set this boundary at the beginning of the supervision relationship as a part of the informed consent process related to the limits of supervision, and an agreement can be reached regarding when the supervisee may be referred to counseling treatment options.

Recommendations for Navigating Supervision of Addictions Counselors

Supervision of addictions counselors is challenging as well as incredibly rewarding. The following recommendations may assist supervisors of addictions counselors in navigating the often murky waters of supervision in this specialized field.

- *Provide a written contract as part of the informed consent process.* A good offense can be your best defense as a supervisor. A thorough contract sets the foundation of expectations in the supervision relationship and serves as a form of protection for the supervisor. It is easy to forget to cover topics, and a written contract can provide clear information as well as gives both parties a reference document for the duration of the supervision relationship.
- *Directly observe supervisees, if possible.* Supervisors have a responsibility to train and educate supervisees on how to become proficient counselors. If it is possible, direct observation of the counseling skills of the supervisee can provide evidence of skill proficiency and suggest additional training points.
- *Consider utilizing Gottlieb's (1993) exploitive dual relationship decision-making model to self-evaluate the supervision relationship.* Although this decision-making model was developed for use in evaluating counselor–client relationships, it can be applied to supervision relationships. The five steps enable you to evaluate the relationship based on dimensions of power, relationship duration, and status of termination. The premise of the model is that dual relationships cannot always be avoided and are not inherently bad. The model is intended to assist in avoiding exploitive dual relationships.
- *Make boundary discussions a regular supervision topic.* Boundary concerns can arise in various contexts within supervision. Continually addressing boundaries as a regular topic provides a comfortable space to discuss potentially uncomfortable issues.
- *Monitor self-disclosure.* Although the supervision relationship is different from the counseling relationship, harmful dual relationships may be created unintentionally if supervisors do not monitor their own self-disclosure.

- *Seek consultation with other supervisors.* Supervision can be challenging, and a trusted colleague can be valuable in times of particular stress or struggle with a supervisee. Consultation also provides the benefit of objectivity to help a supervisor navigate an ethical dilemma or work with a challenging supervisee.
- *Utilize an ethical decision-making model, and teach it to your supervisees.* There are many ethical decision-making models in the field, but none at this time particularly addresses concerns present in the field of addictions counseling and supervision. Most of the models can be adapted to addiction-related dilemmas and provide a framework for working through ethical concerns within the supervision relationship as well as the counseling relationship.

As a supervisor in the addictions field, much of my supervision session time has been spent helping supervisees gain awareness related to professional boundaries with coworkers, supervisors, and clients. Many of my supervisees, particularly those with addiction experiences personally or in their family, struggle with setting and maintaining professional boundaries. Driven by a desire to help people heal from a devastating addiction, counselors find themselves lured into an enabling role. I have made it a priority to discuss boundaries and self-awareness in my supervision sessions regularly, in almost every session. I also emphasize the need for a self-care plan. I have struggled to engage in solid self-care as a supervisor. Managing the sometimes conflicting roles as both a clinical and an administrative supervisor has given me many sleepless nights. I have overworked myself many weeks trying to support my supervisees, counsel clients, and complete all my managerial tasks. I have failed many times in my attempts to be "Superwoman/Counselor/Supervisor" and ultimately have found self-care to be the foundation upon which I can be at my best most of the time. Supervisors have an amazing opportunity and a weighty responsibility to help shape and define the next generation of addictions counselors. We all must take a step back every once in a while to gain perspective, revitalize, and adjust to our ever-changing field.

Consultation

Consultation is a form of service delivery that is expected from counselors in a variety of settings. The use of consultation has increased in the past decade because of its utility in promoting social justice, ecological perspectives, prevention, and systems-level perspectives. Consultation, like supervision, is a complex, tripartite process. Consultation has been defined as a process in which a human services professional assists a consultee with a work-related (or caretaking-related) problem with a client system, with the goal of helping both the consultee and the client system in some specified way (Dougherty, 2014). In a phrase, consultation is an interpersonal helping

relationship that employs a problem-solving paradigm to assist consultees to be even more effective in their work. It is voluntary, is temporary in nature, and can focus on remedial or preventive issues.

Consultation involves at least three parties: a consultant, a consultee, and a client system. Consultees typically are other human service professionals, related professionals such as teachers, and caregivers (for example, parents). The client system can consist of an individual, a group, an organization, or a community. The consultant may take on a variety of roles when providing consultation. In spite of this possibility, many counselors equate consultation with being an "expert" (Dougherty, 2014). Although consultants take on an expert role when necessary, they typically assume a collaborative stance when assisting consultees and may take on a variety of other roles depending on consultee needs. As a result, the consultee is actively engaged in all aspects of the consultation process.

It is important to note that consultation can be effective in promoting prevention as well as in dealing with remedial issues. Consultation can support the prevention of psychological problems and can be used to foster positive mental health in society. By engaging consultees in consultation, consultants create the conditions by which consultees become more effective with similar situations in the future, thus having a preventive effect. Consultation's remedial capacity is most often emphasized, and its preventive possibilities have only recently begun to receive attention from the helping professions, including counseling.

Although counselors are often the service providers for consultation, consultation is not the same as counseling. In fact, consultation deals exclusively with the consultee's work-related problems and thus by definition does not deal with the personal concerns of the consultee. Nevertheless, in actual practice it can be difficult to determine where to draw the line between consultation and counseling. When this line is crossed, a dual relationship is created. Dual role conflicts also occur when a consultant functions as a supervisor to a consultee. Consultants may ponder these questions in their work:

- How can consultants set clear boundaries to distinguish between work-related and personal concerns of their consultees?
- How can consultants best avoid potential role conflicts?

Role conflicts often occur when a consultant blurs the boundaries between the professional and personal concerns of the consultee. The following example illustrates how this can occur.

> Willene contracts with a community mental health agency to provide consultation for volunteers who work with people who are dying and their family members. Willene has been hired as a consultant by the agency director to teach people basic helping skills (listening, attending, and some

crisis intervention strategies). Willene is working with these volunteers as a group, and many of the participants express a need to talk about how they are affected personally by working with those who are dying. Their work is opening up feelings of helplessness, fears of dying, and unfinished business with grieving their own losses. Willene decides that it is more important to attend to the needs being expressed by the volunteers than to focus on teaching them helping skills. Her interactions with the volunteers focus more and more on helping them explore their personal issues and only secondarily on teaching skills.

- To what extent do you think Willene's shift in focus can be supported?
- On what basis?
- What potential dual relationship issues do you see in this situation?

A Contributor's Perspective

Conflicts can occur when a consultant maintains two professional roles in the consultation relationship, such as serving as both counselor and consultant or supervisor and consultant. Michael Dougherty presents a rationale for avoiding these types of dual relationships.

Dual Role Conflicts in Consultation

A. Michael Dougherty

Do the conflicts that might occur when a consultant maintains two professional roles in the consultation relationship outweigh the benefits that serving in the two roles may create? I believe counselors should be extremely cautious before they engage in dual professional roles in the consultation relationship. Generally, when serving as consultants, counselors should minimize maintaining multiple professional roles. My rationale is based on eight considerations.

First, the complexity of the consultation process has contributed to disagreement among authorities in the field as to the boundaries of the consultant's role. Research has yet to define specific and refined boundaries, so consultation relies on broad boundaries. Because of their tripartite nature, consultation relationships are more complex than the counseling relationship, and an additional professional role only increases the complexity of already intricate somewhat ambiguous processes. For example, when does the feedback of consultation become the evaluation of supervision? When does acknowledgment of the negative emotions of a consultee cross the boundary into counseling concerning those emotions?

Second, there continues to be disagreement in the field concerning the definition of consultation, which makes it challenging to define the appropriate roles the consultant can assume when providing these services.

An additional professional role only complicates these difficulties. For example, how does a consultant differentiate a work-related from a personal concern of a consultee and then go about contracting to consult regarding the work-related concern and counsel regarding a personal concern? Because work-related and personal concerns are typically intricately intertwined and consultation is so difficult to define, it is best to limit contact with the consultee to one professional role.

Third, when they consult, counselors should be wary of multiple roles that might create conflicts of interest that could in turn reduce their efficacy. For example, a consultant may be appointed to an administrative position in which a current consultee now also becomes a subordinate. Dual relationships frequently cause conflicts of interest as well as role conflicts.

When providing these services, counselors should be wary of being drawn into any roles that are incompatible with their stated purposes and contract. Counselors should decline to take on additional roles when these roles reduce freedom of expression or objectivity or limit the consultant's commitment to the consultee organization. By engaging in dual relationships when consulting, counselors may easily jeopardize their commitment to the consultee organization. For example, when a consultant takes on the additional role of supervisor, the consultant may be placed in the position of being expected to share information with parties-at-interest about a supervisee and yet maintain the confidentiality of the consulting relationship because the supervisee is also a consultee. Consider the following situation:

> As a consultant, you agree to supervise John, who is also your consultee. In a meeting, John's immediate superior asks you for some information to be used in his annual evaluation. As both a consultant and supervisor you have noticed some professional skill deficits in John and have been working with him to upgrade his skills.

What kind of information could you share as a supervisor without breaking your obligation to maintain the confidentiality of the consulting relationship? The level of difficulty in answering this question suggests that professional dual relationships involve significant risk in terms of conflicts of interest.

Fourth, consultants need to guard against putting the consultee in interrole conflict in which two roles cause contradictory expectations about a given behavior. For example, consultation focuses on work-related concerns, and counseling focuses on personal concerns. Because it is difficult to differentiate these two foci, it is best to keep the expectations as simple as possible so that the consultee will not confuse the two relationships and bring up personal issues during consultation and work-related ones during counseling.

Fifth, the training of counselors conditions them to move naturally toward affective concerns and personal problems, and it is hard to "turn

off" this tendency in other types of professional relationships such as consultation. This tendency can be particularly dangerous if the counselor, when consulting, determines that the locus of the work-related concern lies more in the personal issues of the consultee than in the client system itself. Further, it is easy to move toward counseling consultees when they talk about the anxiety they are experiencing in a work-related problem. Counselors might, therefore, have a tendency to want to offer counseling services to a consultee based on the perception that they will benefit both personally and professionally from such an additional relationship. Focusing on the emotional needs and concerns, however, breaks the peer relationship inherent in consultation and should therefore be avoided.

Sixth, the consultee may have an obligation to his or her organization not to use the counselor's services for personal purposes because the organization has provided consultation services for professional, not personal, growth. Further, if the consultant agrees to provide counseling and this is kept private, the consultee might wonder later what other kinds of "cheating" the consultant might do (e.g., breaking confidentiality). Consequently, dual relationships, if not approved by the consultee organization, may well raise some issues regarding the professional behavior of consultant and consultee alike.

Seventh, if the consultant simultaneously engages in consulting and counseling roles with a consultee, word may get out that the consultant is "a great counselor." Many prospective consultees who have work-related concerns may avoid seeking consultation because they are concerned that the consultant will try to counsel them on a personal level.

Eighth, from the preventive aspect of consultation, consider the relationship of the role of advocacy to the service of consultation. Recently, the advocacy role in consultation has been defined more in terms of advocating for the rights of those who are unable to help themselves or who are oppressed (Dougherty, 2014). From this perspective, advocacy is blended with outreach: the promotion of available services to selected populations. Consultants can act as advocates in a variety of ways, such as, as process consultants assisting groups in becoming self-advocates, as identifiers of target groups needing advocacy, as locators of necessary resources, and as facilitators of advocacy attempts. Advocacy can function as the facilitation by consultants of the empowerment of individuals to advocate for themselves. So the question becomes, when does the consultant's advocacy for the client system end and his or her obligation to the consulting organization begin? The welfare of both is important. This leads to a potential dual role of being a consultant to the organization and an advocate for the client system. On occasion, this may mean that the consultant's concern for the welfare of the client system may be at odds with the commitment to consult with the organization that serves the client system. Consultants have a professional obligation not to engage in inappropriate advocacy roles. Yet they should not avoid situations that dictate that they become

advocates, for example, in a social justice situation. Determining how to proceed can be a challenge. Perhaps it is in the best interest of all stakeholders for the consultant to work within the processes of the organization while pointing out through appropriate channels any issues that require advocacy for the consultee or the client system.

Tack and Morrow (2014) presented a mental health consultation case study dealing in part with boundary issues between consultation and counseling. In this case, the consultant assisted the consultee in developing a self-care plan and also referred the consultee for counseling. The authors pointed out that the self-help plan touched on the boundaries between consultation and counseling, and they suggested that caution is in order in such situations.

In summary, professional dual relationships are best avoided whenever possible when consulting. They make these complex processes and relationships even more complex. The additional weight of another relationship makes it more difficult for the parties involved to conduct their business of assisting the client system in being more effective.

Conclusions

In this chapter we have highlighted the implicit duality that exists in the supervisor–supervisee relationship and have noted the difficulties in determining where the boundary lies between supervision and counseling. Because supervision involves a tripartite relationship among supervisor, supervisee, and clients of the supervisee, supervisors have multiple loyalties. They have obligations not only to the supervisee but also to the clients of the supervisee, the supervisee's employer, and ultimately the profession. When these loyalties conflict, supervisors are confronted with difficult decisions. Supervisors play a vital role as gatekeepers to the profession.

Although it is not appropriate for supervisors to function as therapists for their supervisees, we contend that good supervision is therapeutic in the sense that the supervisory process involves dealing with the supervisee's personal limitations, blind spots, and impairments so that clients are not harmed. Informed consent is crucial in supervision. Supervisees are owed the same kinds of explanations about the potential problems involved in dual relationships as are clients.

We also explored the conflicts that can occur when a consultant attempts to function in the dual role of consultant and counselor or consultant and supervisor. The dual role of consultant and supervisor should be avoided because supervision involves evaluation and thus violates the peer nature of the consultation relationship. Serving as both consultant and counselor is also to be avoided because consultation is designed to focus on work-related concerns. When a consultant determines that a problem resides more in the personal concerns of a consultee than in the client or client system, the consultant should refer the consultee.

Chapter 7

Education and Training of Group Counselors

This chapter focuses specifically on the training of group counselors. We have devoted a separate chapter to this topic because there is controversy regarding how group counseling courses should be taught. At the heart of the controversy is the question of how to manage dual relationships that may occur in experiential training. We address the challenges involved in learning how to manage multiple roles and responsibilities when combining didactic instruction and participation in an experiential group.

It is common practice to include both didactic and experiential aspects of learning in group work courses, but doing so requires that educators address a number of ethical considerations. The guest contributors in this chapter illustrate these issues in the descriptions of their group courses. Group work educators must manage multiple roles and fulfill many responsibilities to their students. In experiential training, participants engage in self-exploration and deal with interpersonal issues within the training group or class as a way of learning how to facilitate groups effectively. Many group work educators believe the potential risks of experiential methods are offset by the benefits to participants who become personally involved in experiential group work as a supplement to didactic approaches in group courses. These educators see a need for an experiential component to assist students in acquiring the skills necessary to function as effective group leaders. It is essential that instructors are aware of the potential dangers inherent in multiple roles and relationships in teaching group courses and that they acquire the necessary competence to teach group courses.

Training Standards for Group Trainees

In master's-level counselor education programs, one course typically covers both the didactic and the experiential aspects of group process. Some

counselor training programs have more than one group course, but many have only one course devoted to teaching knowledge and skills for group counselors.

The Association for Specialists in Group Work (ASGW) has developed three foundational documents to guide training and practice in group work: (a) *Best Practice Guidelines* (ASGW, 2008), which addresses guidelines in planning, implementation, processing, and evaluation in group work practice; (b) *Multicultural and Social Justice Competence Principles for Group Workers* (ASGW, 2012); and (c) *Professional Standards for the Training of Group Workers* (ASGW, 2000).

The ASGW (2000) training standards outline basic aspects in the education and training of group counselors: didactic course work, being involved in experiential group activities, leadership opportunities, and receiving competent supervision. The standards also specify two levels of competencies and related training: A set of core *knowledge* competencies and *skill* competencies provide the foundation on which *specialized* training is built. At a minimum, one group course should be included in a training program, and it should be structured to help students acquire the basic knowledge and skills needed to facilitate a group. These group skills are best mastered through supervised practice, which should include observation and participation in a group experience.

In addition to the ASGW (2000) training standards for group workers, the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2009) standards specifically devoted to group work identify areas in which students in counseling are to develop a set of competencies. The CACREP standard on group work requires

> studies that provide both theoretical and experiential understandings of group purpose, development, dynamics, theories, methods, skills, and other group approaches in a multicultural society. (Section II, G.6.)

In addition to teaching principles, leadership styles and approaches, theories, and methods, training programs also offer

> direct experiences in which students participate as group members in a small group activity, approved by the program, for a minimum of 10 clock hours over the course of one academic term. (Section II, G.6.e.)

Both CACREP and ASGW training guidelines include an experiential component to training group leaders. CACREP (2009) has a 10-hour requirement for direct experience as a participant in a small group. ASGW (2000) requires a minimum of 10 hours of observation and participation in a small group as a member or a leader, with 20 hours being recommended.

The core competencies delineated in the ASGW (2000) training standards are considered to be the benchmarks for training group workers.

The current trend in training group leaders focuses on learning group process by becoming involved in supervised experiences. Both direct participation in planned and supervised small groups and clinical experience in leading various groups under careful supervision are needed to equip leaders with the skills to meet the challenges of group work.

Markus and King (2003) maintain that comprehensive training must include intensive supervision by a competent group therapist. Although Markus and King endorse group supervision of group therapy as a powerful cognitive and emotional learning experience, they report that the majority of internships provided for group trainees use the one-to-one model rather than offering opportunities for group supervision. Group supervision with group counselors provides trainees with many experiential opportunities to learn about the process and development of a group. Christensen and Kline (2000) emphasize that supervisees have many opportunities to learn through both participation and observation. Their investigation lends support to the numerous benefits of group supervision, a few of which include enhancement of knowledge and skills, ability to practice techniques in a safe and supportive environment, integration of theory and practice, richer understanding of patterns of group dynamics, opportunities to test one's assumptions, personal development through connection with others, and opportunities for self-disclosure and for giving and receiving feedback. Participation in a supervision group affords trainees many opportunities for learning, not only from the supervisors who conduct the group but also from others in the group through the questions they raise and the discussions that follow.

In a supervision group for group trainees, students can learn a great deal about their response to criticism, their need for approval, their use and misuse of power, their anxieties over being competent, and their feelings about certain members of the group they lead. Trainees can gain insights into their personal dynamics, such as potential areas of countertransference, which can influence their ability to competently facilitate groups. By identifying areas that can lead to countertransference, trainees are in a position to do further work in their own therapy outside of the group.

Combining Experiential and Didactic Approaches

Although combining experiential and didactic methods in training group leaders is quite common, this practice has led to controversy among group work educators. Some group counselor instructors fail to adequately analyze possible dual role conflicts, which can lead to ethical issues. For example, faculty members sometimes function in multiple roles and relationships with students and trainees without establishing and clarifying appropriate boundaries. Some students who have been in a group course have talked about the experience as being anything but growth producing or a positive learning experience. In some cases, students have not been given any preparation for a

group experience, and informed consent has not been adequately addressed. In other cases, students are left alone to form their own process group, which is a required part of the group course, with very little guidance and no supervision from the faculty person teaching the course. Undirected group experiences have the potential for being aimless or even damaging. Conflicts may not be properly addressed, and scapegoating of a particular member may take place. There may also be undue group pressure for members to reveal personal secrets, and hidden agendas can result in the group getting stuck.

As each of the guest contributors in this chapter makes clear, implementation of various safeguards increases the likelihood of a positive experiential group experience. Most group counselor educators consider the experiential component to be essential for group counseling courses. According to Luke and Kiweewa (2010), participation in an experiential group has many benefits in the areas of personal growth and awareness in addition to offering opportunities for learning about group process. Students participating in experiential training must be willing to engage in self-disclosure, to become active participants in an interpersonal group, and to engage themselves on an emotional as well as a cognitive level. Although problems may surface when teaching students how groups function by involving them on an experiential level, these difficulties can be successfully addressed, especially through an informed consent process. Clear guidelines need to be established so that students know their rights and responsibilities. This arrangement does put a bit more pressure on both the instructor and the students. It calls for honesty, maturity, and professionalism.

Multiple Roles of Group Work Educators

Faculty who teach group courses often function in multiple roles: facilitator of a group, teacher, counselor, evaluator, and supervisor. At various times educators may teach group process concepts, lead a demonstration group in class, set up an exercise to illustrate an intervention in a group situation, and evaluate students' work. Educators may have a monitoring function, especially in intervening when students demonstrate bizarre behavior, are unable to give or receive feedback appropriately, or are unable to relate to others effectively. Group educators have a responsibility to the students, the profession, the community, and the training institution to take action when students in a group course give evidence that they are not suited personally to working as group facilitators.

Goodrich and Luke (2012) address the ethical challenges faced by group counselor educators when problematic students are identified in the experiential group. Group counseling instructors have gatekeeping responsibilities, and at the same time they must facilitate the personal development of students. When students exhibit problematic behaviors, these two responsibilities may be in conflict. Personal information disclosed in the small group cannot be used to evaluate students, but problematic behaviors that manifest themselves in the group context need to be addressed in the group.

When a problematic group member is identified, it is critical that educators follow established remedial and due process policies so that they do not become embroiled in legal action. Goodrich and Luke suggest that counselor education programs take steps toward prevention before problematic behavior takes root in an experiential group.

Faculty members who teach group classes often assume a supervisory role, observing trainees as they facilitate a group. If an instructor also facilitates a process group or an interpersonal process-oriented group, the instructor will at times carry out therapeutic roles and functions with these same students. Although the instructor may avoid becoming a therapist for a student group, he or she might be called upon to assist participants in identifying personal problems that are likely to interfere with their ability to function effectively in group work. Blending these roles presents some potential ethical problems, and various strategies can be employed to address these issues in the preparation of group counselors.

Educational and therapeutic dimensions are often blended in group courses to enable students to obtain both personal benefits and conceptual knowledge and to acquire leadership skills. One core ethical issue is the level of competence of the person teaching the group course. Faculty who teach group courses need to have experienced a group themselves as a member and be adequately prepared to teach group process. Those who teach group courses must guard against exploiting students by using the group as a way of meeting their own needs. Issues of power and control, the undue use of pressure, and bias can cloud the instructor's objectivity and judgment. It is essential to be aware of the potential pitfalls that grow out of dual relationships and to develop strategies to reduce chances of exploiting or harming students.

One of the major risks inherent in experiential training is the potential for the instructor of the group counseling course to misuse power. When instructors assume multiple roles of teacher, group facilitator, supervisor, and evaluator, they need to be mindful of the ways that power can be both used and misused. Smokowski, Rose, and Bacallao (2001) point out that group leaders (and instructors) have a great deal of power, prestige, and status within their groups. A potential danger is that "many leaders are not able to responsibly manage, or even recognize, their power and influence" (p. 228). Kottler (2004) adds that multiple relationships in training become problematic when they are exploitive and when educators misuse their power by taking advantage of others in a dual role. Kottler suggests safeguarding trainees in an experiential group in the following ways: through informed consent, so that students know what they are getting into; providing the right to pass; and not evaluating students on what they say or do not say. Group therapists also have legitimate power by virtue of their leadership expertise and specialized knowledge and skills. Group facilitators can use their status and role to empower the members of their groups by helping them to discover their inner resources and capacities.

Kottler (2004) observes that dual and multiple relationships can add richness and complexity to life. Kottler makes a very important point when he

says that in teaching group counseling the key is not *what* we are doing but *how* we are doing it. As you will see later in this chapter, Matt Englar-Carlson emphasizes how managing dual relationship and boundary issues is associated with an experiential group course. He describes how he structures his course to ensure that his students profit, both personally and academically, from being part of his group counseling class.

Although some abuses in the attempt to train using experiential approaches have been documented, we do not think this warrants the conclusion that an experiential approach is necessarily inappropriate or unethical. Furthermore, it is a mistake to conclude that group work educators should be restricted to providing didactic information. Overcorrection of a problem of potential abuse does not seem justified to us. From our perspective, teaching group process by involving students personally is the best way for them to learn how to eventually set up and facilitate groups. We are in agreement with Stockton, Morran, and Krieger (2004), who indicate that there is a fine line between offering experiential activities and safeguarding against gaining information that could be used in evaluating students. Faculty who use experiential approaches are often involved in balancing multiple roles, which requires them to consistently monitor boundaries. Stockton and colleagues emphasize that group work educators need to exert caution so that they offer training that is both ethical and effective.

It is not possible to completely eliminate the potential for negative outcomes, especially if the form of learning is intense and meaningful, but students who are informed of their rights and responsibilities are less likely to be exploited. Adequate informed consent prior to admission to the program and prior to taking courses that rely on experiential approaches is key to successful group learning experiences.

A Contributor's Perspective

Holly Forester-Miller and Edward E. Moody Jr. summarize some perspectives on teaching group counseling and discuss how to implement safeguards. They believe counselor educators have an ethical obligation to require students to participate in group counseling experiences, and they argue that the benefits of including an experiential aspect outweigh the potential risks to students, especially if safeguards are designed and implemented.

Dual Relationships in Training Group Workers

Holly Forester-Miller and Edward E. Moody Jr.

The Experiential Group as a Key Component of Training

In the past, counselor educators have debated whether it was ethical or appropriate to require students to participate in an experiential group as part of their training in group counseling. The current literature indicates that a group experience is an essential component of training group counselors (M. S. Corey, Corey, & Corey, 2014; Forester-Miller & Duncan, 1990; Merta,

Wolfgang, & McNeil, 1993; Yalom, 2005). ASGW (2000) concurs, stating that the practice domain should include observations and participation in a group experience, which could occur in a classroom group. Shumaker, Ortiz, and Brenninkmeyer (2011) found that counseling programs utilize experiential groups approximately 90% of the time to prepare group counselors. Experiential groups are a vital part of training effective group leaders.

Opportunities for Practicing Skills

In teaching individual counseling skills, we demonstrate and role-play counseling situations for our students. The students also practice their skills on one another, for several reasons. First, it gives them a "safe" place to practice. Second, they can give one another valuable feedback based on their counseling knowledge. Third, it gives them the opportunity to experience the counseling process from the client's perspective. These same reasons are relevant to the practice of group counseling skills. In group counseling the process and dynamics are very different from individual counseling, and skills are of no value if the counselor does not understand the process and dynamics that are occurring in the group. Students can read about group process, but until they experience it, we do not believe they can fully understand it. Students have told us time and again that they thought they understood what the book was saying about the stages of a group but that it was so different to actually watch the process occur in our personal growth group. This is especially true of the dynamics that occur during the stage we refer to as the *transition* or *storming* stage. For example, it is extremely helpful for students to see the leadership being challenged, to observe the nondefensive response of an experienced leader, and to be able to discuss that experience with the leader as part of a class discussion.

It seems to us that it is our ethical obligation to require students to participate in a group counseling experience. It is no longer a matter of *whether* it is appropriate; the question now is *how* this group experience can be offered in an ethical and appropriate way.

The *ACA Code of Ethics* (American Counseling Association [ACA], 2014) deals with this issue:

> Self-growth is an expected component of counselor education. Counselor educators are mindful of ethical principles when they require students to engage in self-growth experiences. Counselor educators and supervisors inform students that they have a right to decide what information will be shared or withheld in class. (Standard F.8.c.)

Minimizing Risks of Experiential Groups

Much can be done to reduce the risks of conducting experiential groups. Okech and Rubel (2009) recommend that instructors engage in systematic "supervisor apperception" to provide high-quality training and reduce

the occurrence of ethical dilemmas. Ongoing self-reflection can reduce the risk that unintended manipulation, coercion, or exploitation will take place. Shumaker et al. (2011) noted that with proper safeguards the risks of experiential group training can be further reduced with informed consent and self-disclosure training for students, along with systematic instructor self-reflection. These are critical components for promoting a positive experiential group experience.

The personal growth or training group experience built into group counseling courses is very different from a therapy group. The main differences lie in the intensity of the experience and the depth of sharing on the members' parts. Yet the stages of the group and the leadership issues at each stage remain the same, thus offering a wonderful learning opportunity while minimizing the risks to students. As long as counselor educators properly plan for the group experience and, as with any group, design the experience always keeping in mind the purpose and objective of the group and the best interests of the participants, the risk of harm from the dual relationship will be minimal. Goodrich (2008) noted that the emerging literature challenges the assumption that dual relationships must be inherently bad, noting that these relationships have been found to benefit the personal and professional development of students while increasing their critical thinking skills. Students can learn that what is critical is to manage dual relationships. Students can work through ethical concerns associated with dual roles and relationships in a training program.

Forester-Miller and Duncan (1990) recommend several guidelines and conditions under which the risks to students are minimized. Several that apply here and have not already been mentioned are that the personal growth experience not be related to the process of program screening, whether for admission or for continuing in the program; that students be evaluated only on their level of group skill acquisition; and that students not be allowed to lead a group of their peers without the professional responsible for the group being present.

In addition to offering guidelines, Forester-Miller and Duncan (1990) provide four alternatives for structuring a group experience for students that meet the conditions suggested:

1. The master's-level group experience is led by postmaster's students under faculty supervision.
2. The instructor leads or coleads the group, utilizing a blind grading system for assessing students' learning and skill acquisition.
3. All students are required to participate in a counseling group that is external to the academic setting.
4. The instructor leads the group with students utilizing the role-play technique.

These are all viable options open to the counselor educator who teaches group counseling.

Instructor-Led Experiential Groups

We prefer to lead the group and utilize a blind grading system. This approach offers several benefits to students. They are able to experience the "real" thing firsthand: They see the group process at work and at the same time experience it from the perspective of the client. The students have the opportunity to try on the leadership role in an ongoing group with the faculty member present to offer assistance and feedback. The students are provided with an effective leader role model, and the faculty member can feel confident of the skill level being demonstrated and the types of techniques being modeled. This approach also provides a common experience for the students and the instructor to utilize in discussing group process and giving examples. Further, it affords students the unique experience of seeing the faculty member utilizing the skill and applying the strategies that have been discussed, and being able to discuss the effectiveness of the interventions in various situations.

Davenport (2004) recommends requiring a personal growth group prior to taking the advanced group counseling class, led by a licensed professional, often staff of the student counseling center. This is consistent with Forester-Miller and Duncan's (1990) third alternative. The drawbacks to this approach are that some programs do not have access to the resources for providing these groups, the program faculty do not have a means for monitoring the skill levels of the leaders and the skills modeled, the students do not try on the leadership role, and there is no opportunity for the faculty member to discuss the examples from group and utilize these wonderful teaching moments. But despite these drawbacks, it is clearly better than not requiring a group experience at all.

In 1995 Forester-Miller and Remley surveyed members of the ASGW regarding their perceptions of the effectiveness of the group training in their master's degree counseling programs. At the time ASGW had approximately 3,000 members, and 600 of them were surveyed randomly across the country. The study was based on comparing the perceived effectiveness of the five training methods delineated by Merta and colleagues (1993). The training methods included no experiential group, a no feedback experiential group, a feedback experiential group, an instructor-observed experiential group, and an instructor-led experiential group. Respondents who were taught utilizing the instructor-led experiential group model indicated that they gained a higher level of competency in processing interactions and in managing groups as the leader than did the other respondents. In updating and expanding the Merta et al. study, Shumaker and colleagues (2011) found that of the approximately 90% of counseling programs that utilized experiential groups to prepare group counselors, a third of them relied upon the course instructor to teach both the didactic and experiential course components. Fifty percent of the time someone other than the course instructor conducted the experiential portion. The

2011 sample was more likely to incorporate informed consent into the curriculum, with 80% including a statement of purpose and potential risks in their teaching materials. Though it could not be quantified, the narrative section indicated that respondents had a clear understanding of and had carefully considered the risks and benefits of experiential group training. As suggested by Forester-Miller and Duncan (1990) and provided for in the *ACA Code of Ethics* (ACA, 2014), it is possible to safeguard students in instructor-led experiential groups.

Groups Led by Doctoral Students

Ieva, Ohrt, Swank, and Young (2009) found in a qualitative study of an experiential group led by doctoral students that the master's students experienced personal growth, professional growth, and a better understanding of the programmatic aspects of the group. In particular, the students reported growth in the area of empathy, believing their participation in the group would help them better understand their future clients as well as equip them with real-life knowledge about group process and dynamics. All of the participants reported growth in self-awareness and progress in their own development as a counselor. Regarding group leadership, participants noted feeling confident about their ability to facilitate a group. They also believed that the participation enabled them to develop their own personal facilitation style.

A Key Message

The benefits of such an experience certainly outweigh the risks, especially if the faculty member has planned the experience to minimize these risks. It seems to us that we owe it to our students and to their future clients to provide the best training possible, utilizing the most effective teaching methods available. Therefore, not offering a group counseling experience as part of group counselor training would be neglectful and unethical. We emphasize that some dual relationships and dual roles are not only ethical, but beneficial.

A Contributor's Perspective

Matt Englar-Carlson takes the position that managing dual relationship and boundary issues is part and parcel of being a counselor or doing almost any type of group work. As a faculty member and a group counselor educator, he believes it is best to clearly state this from the beginning so students can develop some awareness of and sensitivity to addressing dual relationships in their work. He describes learning how a group works by participating in an experiential group with opportunities to process facets of both group membership and group leadership.

An Experiential Approach to Teaching Group Counseling

Matt Englar-Carlson

Each year I teach two to three group counseling courses for master's students in counseling; these courses are certainly experiential, as the entire class could be considered a "lab experience." I teach the course in semester (one meeting per week for 16 weeks), summer (twice a week for 8 weeks), and intersession (5 days a week for 3 weeks) formats. In most of my group leadership experiences, some boundary issues have needed to be addressed in the group. It is important to note that this group course rests within a counseling program that values self-reflection and openness to change. Every course in the program requires some degree of personal examination, and this expectation is clearly detailed on our departmental website and in application materials. Self-reflection is expected in writing assignments, and opportunities for self-disclosure are plentiful in most classes. Students take the group course at the midpoint of their program; thus, they have already engaged in a lengthy process of examining their own personal growth and have had moments of self-disclosure with students in other classes. At this point in the program, many students are on the cusp of feeling comfortable sharing more of their personal lives and revealing more of their inner worlds with other students.

An Interpersonal Perspective

Each class meets for 3 hours. In the first half of class we operate as a live interpersonal group, discussing whatever concerns the students choose to bring each week. Students are encouraged to talk about topics that are meaningful to their personal lives and growth, and I encourage students to frame their topics and goals using an *interpersonal lens* (i.e., How does the topic influence their relationships with others?). As the facilitator, I actively help students frame their topics and goals from an interpersonal perspective. For example, one student talked about feeling isolated and somewhat depressed after moving from the East Coast to the West Coast. I asked him, "How does moving here affect your relationships with your peers at school, and those in the class right now?" He added, "I feel on the outside, like an outsider, and it is really hard for me to initiate conversations because everything is new. I feel intimidated, as if no one notices me and they do not want to talk to me." I reframed his goal, "So it sounds like you would like to use the group as a place to examine how other people experience you, and it might also be a place to take some risks to develop more meaningful connections." At times some topics or themes may require more support and attention than the group can provide. When that is the case, I encourage students to hold back in the group and to seek help elsewhere (I also help facilitate that referral if they are not already in

counseling). Students often talk about their relationships with friends and family and romantic relationships, but also about being lonely and alone, social anxiety, lack of confidence, death, loss and grief, and coping with developmental transitions. The content of what they talk about is important, but I make a clear distinction between content and exploring their own process of these experiences and concerns. Students can offer support to one another, ask questions, and share their thoughts and ideas. Of course, they can share impressions of one another in the form of feedback.

Identifying Personal Goals

As we close the opening group, I ask students to set clear personal expectations for what they would like to achieve in the group. I ask the students this question: "Imagine it is the last day of class and you say, 'The group was really useful to me and I got want I needed.' What would have to happen (goal) in the group and what would you have to do to make it happen?" Students then share their response at the beginning of the second class meeting. After 90 minutes in the group, we take a short break to clear our heads and designate a shift in focus, and we then use the second half of the class to deconstruct the group process, dynamics, and leadership from the first half of class. This is a didactic format in which students use their reading and growing understanding of group process to learn about group counseling. Students cannot use the second half of class to continue processing, finish, or add more to the earlier group discussion. For example, if a student says, "I really wish I would have told Julie how brave I thought she was," my response would be to stop her and say, "You can save that for next week." Our class parallels groups in the community: Group work and business is completed within the group and not outside of it.

Addressing Boundary Issues From the Outset

Without a doubt this format is rife with dual relationships and boundary issues, and we address these issues with utmost transparency. As their instructor and a faculty member, one of the first things I address is the power I hold associated with evaluation in the class and their overall fitness as counseling graduate students. I do evaluate them in the class and in the future. I will most likely be their adviser and teach more of their classes. I tell students that I will not share personal topics they talk about in the first half of the class with others, including other faculty, unless they want me to do so. If I have concerns about them as students and counselors-in-training I promise to talk with them privately about working through those concerns and getting the needed help. Of course, students have many dual relationships as well. They are present and future colleagues, friends, and often roommates. They will see one another in many classes and potentially in future careers. At first, students often see that as a negative ("People will learn about me and that is terrible"), but I work to reframe that into the potential

building better relationships for one another. With the prospect of future relationships and interactions with one another hanging in the air, I often comment that after being in a class like this and working together, there is a good likelihood they will remember their classmates more and develop a stronger bond together that can evolve over time.

Informed Consent

Students are given informed consent about the risks and benefits of the group course. Although students have to be in the classroom for the entire class period, they are given the option to say *absolutely nothing* (outside of checking in each week with their name and something about how they are doing) and not participate in the first half of the class. However, I make it clear that everyone in the class is a part of the group, and the group will discuss the process alive in the room each day. Even though a student may be silent, it does not mean that the group will not discuss the impact of the student's silence on the room. I make it clear that nothing in the first half of the class is graded or evaluated outside of students' physical attendance. I tell the students this because their participation needs to come from them and not be coerced by me or occur because students feel forced to perform for a grade. Grades in the class are derived from a field-based paper examining group process and leadership in the local community and from a self-reflection paper about students' roles in the important groups of their lives (including the class group). I want their engagement to be voluntary and at their own pace. For certain, some students are quieter than others, but after teaching this class more than 30 times, I have found that no student has been able to stay quiet for the whole course—not even close. I have to admit this is a paradoxical move on my behalf. I pledge to protect any student's right not to say anything because I know that many students who remain quiet are concerned about not having control over their participation. I side with them, boost their feeling of control, and effectively disarm their fear. With the fear removed, students often begin to engage in the process. Also, it just takes some students a bit longer to feel comfortable in a group, and so students are allowed to move at their own pace for engaging the group. I also highlight the value of being a spectator, reinforcing that group members learn by observing others.

Invitation to Actively Participate

A nonparticipating student in the group can create some conundrums for the individual student and the group, but over time I find that students ease into the process if they are not being forced to engage. I do invite quiet students to become more involved in the group, and I work to reframe the question of "Why are you not participating?" to "What makes it hard to participate in this group?" I firmly believe that students are continuously learning, processing, and being affected by the group regardless

of the amount of their verbal participation. They have outlets to share in the group, and most students are also keeping a group journal that can serve as a processing outlet. Students always convey something to one another, and that becomes part of the group process and something to be discussed. For quiet or withdrawn students, I work to draw attention to their nonverbal "impact" on the group. Other members are often more curious than upset at quiet members and want to find ways to bring them into the group.

Benefits and Risks of Experiential Learning

I am aware that students are mainly conscious of the risks, and they have a hard time seeing the benefits of experiential group learning. The risks they fear are not without merit. They fear speaking in groups, they are worried about being coerced to say more than they want, and some have emotional scars from previous group experiences. Mainly, however, they are nervous about how the process works and what might happen if others in the group learn about the parts of themselves they do not like. For me, this latter issue of the fear of being *truly* known is the crux of experiential group work and is deserving of a conscious reframe. Whereas I understand the fear of being known to others and potentially to oneself, it is also worth noting the rarity of opportunities of being known, and how meaningful relationships flow from honesty and revealing who we are. Each group has the potential of being a freeing experience in which group members can be honest and receive real feedback they usually might not get. I query the group, "Where in your life do you get the opportunity to ask for honest feedback?" I offer a subtle challenge that I hope students take the opportunity to ask how they are experienced by the group. On this point I note both the fear and the attraction of such an opportunity, and I make it clear that students can direct the type of feedback they get. For example, they can ask only for positive feedback and may stop the process at any time.

Safeguards

There are many safeguards in this group experience (e.g., no one will be made to speak if they do not want to, you will know why you are being asked certain questions before you answer, you can always decline to respond, material from the group is not to be discussed or shared outside of the course, in the second half of the class we only conceptualize the group process and not the individual members), and for the most part students follow them. When these safeguards are violated or threatened, and at some point in the class (and in most groups) they usually are, we explore how it affects the group. Everything that happens in the course is grist for the mill, so when students do not follow the safeguards, we get a real in vivo experience of what happens in real group settings with boundary violations and when rules are broken. I see these as learning experiences,

and I wonder, how else will students get to learn about true group process dynamics? Group counseling courses often emphasize learning to be a group leader; what may be missed is also learning how to be a good group *member*. Students are reminded that everything they feel, think, fear, and crave in the class is real and that their future group clients will most likely have the same experiences. Group counseling textbooks are just words on a page; they do not become real or alive until the process itself is experienced and felt. Once students have sensed a group dynamic, we can then deconstruct it by making sense of the process issues that underlie it. I would rather have students experience and learn about these dynamics in a controlled setting before going out into the field.

A Therapeutic Emphasis

An important distinction made in the first day of my course is that this is not group therapy, though it can certainly be therapeutic. I actively encourage students to examine meaningful themes, but this course may not be the best place to explore some experiences. Students are encouraged to question what is appropriate and useful for them in the class. I also make it clear that my role is as a group facilitator and not a group counselor. I will not push students beyond their comfort zone or their goals, and I take a cautious path when working with the group. I ask permission before proceeding and invite students into the group rather than directly engaging them. In the second half of class, I will talk about some of my choice points in deciding not to deepen the process and how group counseling might look different.

My Role as a Group Facilitator

In my role as group facilitator, I use the metaphor of "pulling the curtain back on Oz" as a way to reveal to the students all of my reasons for intervening. I want them to know what I am thinking, sensing, and concerned about—and to see the logic and mechanics behind my actions. My pledge to the students is to share, for better and worse, why I did certain things and to share my own process as group leader. It is critical to show that there are rarely "right" answers as a group facilitator; each moment in a group presents a multitude of possibilities for interventions and actions by a leader. Leaders make choices (some better than others), but they learn to be flexible to match the group's needs and recognize that confidence and humility go hand in hand in working effectively with a group.

Modeling the Management of Boundary Concerns

As the course instructor and group leader, I feel confident in my abilities to facilitate the group and also know that each moment in the course I am serving as a model of appropriate group leadership. This final point is worth further examination. As a counselor educator, it is imperative to be knowledgeable about

curriculum, but equally important is the ability to behave as an ethical and effective counselor. This class is an opportunity to model counselor behavior and tie it to the knowledge base of group dynamics and leadership. I effectively show students how to manage dual relationship and boundary concerns: This is the moment in our training program to put away the textbook and comfort of a podium or lecture and show how it is done. Faculty members do plenty of talking the talk—now is when I walk the walk. I show the students my ability to facilitate a group, to explore difficult topics and conflict, to trust the group process, and to model staying in the here-and-now. Like any group leader, I discourage out-of-group conversations about the group, which can be difficult because students and faculty have a good amount of contact with one another in the program and in other classes. When students come to me with questions about their experience or reflections about the group, I encourage them to bring it back to the group. For me, there is no truer example of "integrating knowledge into practice" than this course.

Outcomes of the Group Experience

I am an empiricist: The data do not lie, and this class is easily the highest student-rated course in our department. Students personally learn a great deal about themselves and often comment about understanding the "magic" of group work. There is often a trajectory to a good outcome as students struggle at times in the group process when conflicts are not immediately resolved or when unfinished business carries over from week to week. Of course, that is common in all groups, and students learn to "trust the process" as they have the benefit of seeing and "feeling" it evolve over time. We often finish our class by planning a termination session where we say goodbye by sharing positive impressions of one another. I try to make the final class more of a celebration of the group's work by adding a potluck. During this final meeting we only operate as a group, and we take additional time to process the experience and what each student has taken from it. Students commonly comment on gaining additional confidence by taking risks in the group and feeling validation for their experiences of struggle or marginalization. Students feel supported when they ask for help around issues of grief and loss, they learn that revealing hidden parts of themselves does not bring negative judgment from others, and ultimately they learn that others tend to experience them in much more positive ways than they expected. The group itself often occupies a special place for students, as the connections formed over 16 weeks are real and genuine. Students thus learn via experience that allowing themselves to be known brings deeper connections and better relationships.

My Rewards as a Group Counselor Educator

As I am sure you can tell, I am passionate about teaching this course. It is rewarding in so many ways. First, experiential education is an excit-

ing way to teach, and not knowing what is going to happen each day challenges me as a group facilitator and instructor. Second, teaching this way allows me closer contact with my students, and in many ways, it allows students to have closer contact with me. The relationships I have with students often deepen as a result of this course, and this allows our future contact to be more meaningful. Third, I take a certain pride in seeing students push through their discomfort and learn new things about themselves.

A Contributor's Perspective

In the following article, I (Jerry Corey) discuss how I teach an undergraduate Theory and Practice of Group Counseling course by combining didactic and experiential approaches and how I manage the multiple roles inherent in teaching in this way.

Combining Didactic and Experiential Approaches to Teaching a Group Counseling Course

Gerald Corey

A Unique Undergraduate Group Counseling Course

Currently, I teach group courses on both the undergraduate and graduate levels. Each of these courses blends didactic and experiential approaches, and in doing so I assume multiple roles. In most cases, I teach elective or advanced group courses, which brings a different dimension to these experiences than if I were teaching a required course. In addition to teaching group process as a part of the undergraduate program, I also take on the role of supervisor for students in small groups (as part of the group course). I facilitate groups in which students in these classes are exploring their personal concerns, and a variety of interpersonal issues emerge during the unfolding of a group session. Here I describe a 16-week semester course that I teach each fall at California State University at Fullerton. The course is Theory and Practice of Group Counseling, which is primarily intended as an elective for human services majors who are interested in increasing their knowledge and skill in the various models of group counseling. The course is based on a critical evaluation of 11 contemporary theoretical approaches to group counseling and basic issues in group work. Emphasis is on developing skills under supervised conditions and applying theories and techniques to actual group situations. The course is a combination of didactic and experiential elements involving lectures, discussions, demonstrations of live groups, videos, experiential opportunities as a group member, and practice in coleading a small group at least two times during the semester.

The students who sign up for this undergraduate group course in the human services program are highly motivated and generally willing to

engage in significant self-exploration in the context of the group course. In my role as a professor, I am required to determine a grade for each student, but I am not expected to evaluate students for retention in the major. If I were on a committee charged with making determinations regarding acceptance or dismissal from a training program, and if I were required to use information about students that I acquired from the group courses, this would prove to be ethically problematic.

Students are given a detailed course syllabus at the first class session, which we go over at this meeting. If students determine that they do not want to participate as a member of a group as well as learn about group facilitation, they are certainly free not to enroll in the course. By going over all of the components of the course described in the course syllabus, students are prepared for both the academic and the personal requirements. With this information, students are in a position to determine if this is the kind of learning experience they want for themselves.

At this initial session, I discuss with the students some of the potential problems, challenges, and benefits inherent in a course that combines academic and personal learning. Students are informed that the experience of leading groups, even under supervision, often touches them in personal ways and brings to the surface their own personal conflicts and struggles. It is essential that students be willing to take their own journey toward self-knowledge if they intend to pursue group work. Generally, students hear that they will not be able to encourage future clients to deal with pain in their lives if the students have not become aware of unresolved personal issues and dealt with their own personal pain. Students are encouraged to consider seeking some form of personal counseling as a way to deal with the personal issues that may emerge for them as group trainees. I tell students that this is not a therapy group designed for extensive exploration of their personal problems, but they have opportunities for working on their personal concerns in their small group.

Preparing Students to Colead Small Groups

During the first few class sessions, I offer suggestions aimed at helping students get the maximum benefit from the class and also from their small group experience. I encourage students not to be overly concerned about making mistakes and to be willing to share what they are thinking, feeling, perceiving, and experiencing in the here-and-now of the group session. I emphasize that there is no such thing as a “bad group” because everything that occurs in the class and the small group is an opportunity for learning. Students are given the opportunity to express and explore their concerns and to ask questions about the structure and purpose of the small group. They often mention a fear of getting stuck and not knowing what to do, concerns about being left unfinished, the difficulty they expect to face in switching from member to leader, wondering how far to go with

talking about concerns in their personal life, and their anxieties about the responsibility of coleading a group. During this time I do my best to create a safe climate in which participants feel free enough to practice leading and feel trusting enough to share themselves in personal ways so that they can become a working group.

Small Group Sessions

Over the years I have been able to recruit colleagues to serve as supervisors for these small groups. There are typically about 20 students in a class, and dividing them into two groups calls for a colleague to assist me in supervising one small group. During the first small group session, our main goal is to assist participants in continuing to talk about any fears or expectations they have pertaining to the workshop. In our role as supervisors, we encourage students to identify themselves to one another, which is partly done by defining their personal goals. Through getting acquainted in their small group, the students begin to actively create a trusting environment in which they can engage in the self-disclosure necessary for a working group.

I hope the students learn that their own personal fears, problems, and unresolved issues will affect the way they lead groups. In a small group, other here-and-now issues surface and are dealt with, especially matters such as students' anxiety about not knowing enough to lead groups effectively, fears of being seen as incompetent, discomfort with intense emotions, fear of making mistakes, and concerns about being able to work well with a coleader.

Before the students begin their small groups (which usually happens during the fifth week of the semester), they are given guidelines regarding how they can actively participate in their small groups. To use the time in their small groups effectively, students are asked to focus on two different aspects in their work. The first level focuses on the here-and-now, which pertains to students' reactions to what is going on in their experiential group. Students are told that they will be asked to reflect on what they are thinking and feeling as it pertains to being in their small group. Part of this here-and-now emphasis pertains to their fears, concerns, hopes, and goals as they relate to their group.

The second level focuses on students' personal goals, or the personal topics they are willing to explore in their small group. They hear about the importance of establishing specific and meaningful personal goals. They are asked to pay special attention to personal topics that have relevance to how an issue is likely to affect their work as a counselor or group leader.

During the first 45 minutes of the small group time, students are expected to explore personal concerns that have some relevance to the theory we are considering. During the beginning of the semester, we have a session devoted to cognitive behavior therapy in groups. In the small groups,

students are encouraged to participate by identifying and exploring one of their self-defeating cognitions. Very often students burden themselves with perfectionistic demands that they should already know everything there is to know about a group before they even take the class. Student trainees worry a great deal about their performance and how the supervisors will judge them. Some students are convinced that the supervisors will "discover them" and tell them they cannot continue in the course. They fear being exposed as incompetent. All these beliefs affect how the students feel and act. Their concerns make excellent material to work on in this session devoted to sharing how their thinking influences the way they feel and behave. Some of the most useful themes pertain to their concerns about doing well in this group course, which we invite members to talk about. We caution participants about avoiding an abstract and impersonal discussion.

During this 45 minutes of group time, the supervisors take notes that we later share with the students when we process the group. Our observations and notes about the unfolding of a group session constitute teaching points during the process commentary time that immediately follows. Many aspects of what is going on in the group get our attention:

- How do the coleaders open the group?
- How do they introduce techniques?
- If there is a theme, do the coleaders facilitate group interaction and assist members to deal with the theme in a personal way?
- Are coleaders able to drop an agenda to pick up on an emerging theme in the group, such as lack of trust?
- What leadership skills are the coleaders demonstrating? Are they able to orchestrate member interaction, or do they focus on the first person who speaks and ignore others?
- What are the results of certain interventions?
- Are the coleaders paying attention to nonverbal language?
- Are they able to move from one person to another in a natural way?
- What are the coleaders modeling?
- How is conflict dealt with in the group?
- How are the coleaders working together? Do they pick up on each other's interventions?
- What leadership skills do they need to acquire or refine?

These are a few examples of what the supervisors focus on during the first 45 minutes of each session that the students are coleading. The students are generally receptive to learning about group process immediately after they have experienced the unfolding of a group session.

The Process Commentary Time

The second part of each small group session (approximately 30 minutes) begins with our request that the coleaders talk to each other about what they

were thinking and feeling during the past hour. We then ask the student group members to briefly summarize their experience. Then, as supervisors, we share our observations in such a way that participants are encouraged to interact with us through questions and discussion. During the process commentary, we emphasize that many appropriate clues can be recognized and explored during a group session. What a leader decides to focus on is not a matter of "right" or "wrong." Rather, it is often a function of the leader's interest at the moment. Leaders might make a certain intervention (or avoid doing so) because of their theory, their lack of comfort with certain emotions, their personal blocks, or the mood that seems present in the group. We tend to focus on what the coleaders had in mind with certain interventions and sometimes talk about alternative ways of intervening.

During this process commentary time, we might ask coleaders open-ended questions designed to help them reflect on their own experience as they were leading. Some of these key questions include the following: What was going on with you when . . . ? Were you aware of thinking or feeling something that you did not say? What hunches did you have when . . . ? Where might you go if you were to continue in the next session? Why did you introduce this particular technique at this time? As we discuss what transpired during the session and provide feedback, we try to be constructive, honest, and sensitive. We encourage students to build on their strengths and try not to discourage them from trying out new ideas and approaches.

At times the supervisors have to give difficult feedback, yet we attempt to say what needs to be said in a respectful and tactful way. Typically, after the first small group and our process commentary, the participants relax and feel much less anxiety. They watch the way we as supervisors give feedback, and they see that our intentions are to facilitate what is going on in the group, not to be dogmatic in our interventions and comments. We give the students room to learn by trial and error. Also, we encourage students to be patient with themselves and not to burden themselves with unrealistic expectations of having to be perfect.

Structuring the Small Groups by Applying Theory to Practice

During the first 4 weeks of the semester, we address topics such as ethics in group work, stages of a group, group leadership skills and roles, and ways of best participating as a group member. Each class meeting is for a 3-hour block. Seventy-five minutes is allocated for the small groups, which begin at the fifth week. As a part of the syllabus, the students are given the following description of the purpose of the small groups and what is expected of them:

> Participation is expected in this course. This class will involve some degree of self-exploration and interpersonal learning. You should know that about half of this course will be taught largely in an *experiential* manner, which means that you will be a part of a working group. You are expected to be

> an *active participant* in this group class. Although it is expected that you will verbally involve yourself in an honest exploration of your personal issues, it is up to you to decide what concerns you will reveal and are willing to discuss in the group. It should be noted that you are *not graded or evaluated* on the basis of your participation in the small groups—either in the member or leader roles. In other words, the quantity and quality of your self-exploration and progress in self-awareness and personal growth are *not* factors weighed in your course grade. We will talk more fully about the guidelines for self-disclosure and the expectations at the first class meeting.
>
> The main purpose of the small group is to give you a chance to learn about ways of applying the basic ideas and techniques to group work—from the perspective of a member and a leader. The experiential practice is primarily for learning about group process, and thus it is not a therapy group. Do keep a good record of your reactions to this experience and process notes about the group in your journal, as you will be expected to write about your experience in this group, as well as your learnings from observing these groups in class. As members of this group class, each of you are expected to decide upon a small and realistic goal that will guide your active participation each week. Think of a personal issue relative to each model that has relevance to your effectiveness as a group facilitator.
>
> Each of you are expected to have read the assigned chapter in the textbook and to have worked through the material in the corresponding chapter in the *student manual* on the assigned dates in the course outline before the lectures and small groups on that theory.

During the first 90 minutes of each class, we meet as an entire group. I encourage students to raise questions based on the theory of the week, and I share my perspectives on the key concepts and techniques of each of the theories. I also do a live demonstration with a group showing how I apply some of the key concepts of each theory we are studying for a particular week. These theories include psychoanalytic, Adlerian, psychodrama, existential, person-centered, Gestalt therapy, transactional analysis, cognitive behavior, rational emotive behavior therapy, reality therapy, and solution-focused brief therapy. This demonstration group lasts about 20 minutes and is just before the break; it generally serves as a useful catalyst to focus the members on some personal aspect of the theory they can share in their group. In their small groups, the students are expected to do their best to think and practice within the spirit of the theory of the week.

Concluding Thoughts

My colleagues and I take care to combine both the experiential and didactic dimensions, based on our conviction that such a balance is essential for learning how to lead groups. However emotionally intense the groups may become, we do not abandon the educational aspects as the students are involved in their experiential group. We operate on the premise that

the students can be involved in personal self-exploration and still put their learning into a cognitive framework. The focus on exploring their own struggles stems from our assumption that leaders cannot inspire others to do what they are not willing to do themselves.

I strongly endorse participation in a group as part of a group leader's training. Learning from books and lectures is important but has its limitations; certain skills can best be learned experientially. Struggling with trusting a group of strangers, risking vulnerability, receiving genuine support from others, feeling joy and closeness, and being confronted are all vital learning experiences for future group leaders. A group experience provides a deep understanding of what clients face in groups, which makes such an experience indispensable for future group counselors.

Teaching this course for more than 30 years has given me ample evidence of seeing in action the benefits of using a combination of didactic and experiential methods in helping students gain a greater appreciation of their interpersonal style based on their participation in groups. This approach has convinced me that students can be highly personally engaged in a university course and at the same time can learn how to think about how group theory applies to practice. Students typically make real strides in expressing themselves verbally and in being able to conceptualize and write meaningful papers. Over the many years of reading student papers that conceptualize their personal learning as well as what they learned about group process and facilitating a group, I continue to find that the majority of students greatly benefit from putting into action what they are learning from reading, lectures, and discussions about group work. Many who have been in this course have let us know how valuable the experience was when they went to graduate school in either counseling or social work. As for me, I have never grown tired of working with undergraduate students who are eager to learn and willing to get involved. It continues to be a real joy to be carrying out a multiplicity of roles as I work with students each year. My role is not simply one of giving students information about theories of group counseling but of assisting students in thinking of ways to apply the ideas in the course to their lives personally, as well as thinking about ways they can become more effective facilitators of groups.

After reading the views of Holly Forester-Miller, Edward E. Moody Jr., Matt Englar-Carlson, and Gerald Corey, what are your views regarding the experiential group as a basic component in training group counselors? How do you think you might respond in the following situation?

As a part of a master's degree training program for group counselors, students are engaged in supervised work that involves facilitating an experiential group for the introductory course in counseling taken by all students in the counseling program. Some of these beginning students, who are also required to enroll in a section of a self-exploration group as

part of the introductory course, are wondering about the ethics of having other students in the role of facilitator. A few oppose the idea of being expected to self-disclose in a group setting with student leaders, even though these leaders are under the supervision of a faculty member. The complaining students think that this is a dual relationship issue because their student leaders are enrolled in the same program.

- What do you think about the practice of using students to facilitate self-awareness groups for other students, assuming they are given adequate supervision?
- What safeguards can you suggest to protect both the student facilitator and the students who are members of the group?
- If this group were conducted by a faculty member who teaches the group course (and who is likely to have the students in a future class), what issues need to be addressed?
- If you are a counselor educator who teaches group counseling courses, where do you stand on the issues raised in this chapter?
- What safeguards do you think are necessary to protect both students and the public they eventually will serve?
- If you are a student in a counselor education program, what are your reactions to this controversy?
- What kinds of learning experiences do you think you need as a student to become an effective group leader?

Conclusions

The issue of dual relationships in the education and training of group counselors is far from being resolved. Conscientious counselor educators may face an ethical dilemma in the way they train group leaders. On one hand, if we remove ourselves from what many consider to be problematic dual roles (such as combining didactic and experiential learning by performing multiple functions that may include any combination of instructor, supervisor, group leader, and consultant), we are vulnerable to charges that we have abdicated our responsibility to the profession, to the public to ensure competent service, and to providing students with the best kind of learning experience to equip them to competently lead groups. On the other hand, if we do teach by combining roles, we may be vulnerable to charges that we have abdicated our responsibilities to respect the privacy of our students.

Regardless of the model instructors use, we believe the key elements are the qualifications of instructors and the way the model is implemented. A given model may not itself present a problem, but how specific instructors implement it may create problems. It is crucial for the instructor to be open, to treat students with respect, and to make the expectations for the course clear from the outset. It is essential to keep in mind the primary purpose of a group counseling course, which is to teach students

leadership skills and to provide an understanding of how group process works. Although the main aim of a group course is not to provide personal therapy for students, participating in such a group can and ought to be therapeutic. Students can make choices about what personal concerns they are willing to share, and they determine the depth of their personal disclosures. A group course is not designed to be a substitute for an intensive self-exploration experience, but learning how groups function can be enhanced through active and personal participation in the group process.

It seems obvious to us that counselor educators need to continue to work to clarify the question of how group counseling courses can best be taught. If counselor educators choose to keep group experiences free from evaluation, then other procedures need to be implemented within the program to screen out unsuitable candidates. At this point, counselor educators have a wide range of choices in preparing students to be group counselors. We each must choose according to our own stance on the issues, balancing our responsibilities to our students, the profession, and consumers of counseling services.

Chapter 8

Group Counseling and Couples and Family Counseling

In this chapter, we look at boundary issues that often arise when working with multiple clients in the context of counseling groups, couples, and families. Our guest contributor, Amy Manfrini, shares her way of establishing boundaries for couples counseling and family therapy.

Group Counseling

Boundary issues can be particularly complex when counselors are dealing not only with multiple roles and relationships but also with multiple clients, as is the case in group counseling. Questions that provide a framework for our discussion here include the following:

- How can group leaders determine what kinds of personal and social relationships with group members are appropriate or inappropriate?
- Are there potential conflicts in admitting a former client into a counseling group? How about a friend or acquaintance?
- What are the limits of group leader self-disclosure? How could overextending the boundaries create a dual relationship?
- In a productive group, when leadership and membership roles may become blurred, what role conflicts might emerge?
- Are role conflicts inherent in serving as both the client's individual counselor and the group counselor?

Personal Relationships in Group Counseling

How can group leaders distinguish between appropriate and inappropriate personal and social relationships with members of their groups?

We think it is inappropriate to use our professional role to make personal and social contacts, and it is certainly questionable to develop such relationships with current group members. In fact, we urge group counselors who look to their therapeutic groups as a source of friendships, or as a way to enrich their social lives, to examine their own personal needs and motivations. Group members should not be expected to perform the function of filling gaps in the therapist's personal and social life.

Establishing friendships with current group members can put a strain on the therapeutic relationship and can cause problems for the group leader, the member involved, and other members of the group. The group member might be inhibited from participating fully in the group for fear of jeopardizing the friendship. In addition, singling out an individual member as a friend is bound to affect the dynamics of the group. The members who are not chosen as friends are likely to feel rejected or resentful.

It is more difficult to handle the dual relationship issues that arise when personal and social relationships develop among group members. Pregroup screening can help to identify preexisting relationships among potential members that could be problematic. However, in small towns it may be impossible to form groups composed of people who do not already know each other. Even in urban areas where it is possible to screen for prior relationships, it is probable that certain members will feel drawn to each other as the group progresses, and they may want to form personal relationships outside the group. This has advantages and disadvantages. When members socialize outside of group sessions, group cohesion may be increased. Yet such a practice can also destroy the cohesion of a group. If members become a social group that discusses group matters, and if they refuse to bring those matters into the group itself, the progress of the group is inevitably impeded. Other signs that indicate counterproductive socializing include forming cliques and excluding certain members from social gatherings, forming romantic involvements without a willingness to acknowledge these involvements in the group, refusal to challenge one another in the group for fear of jeopardizing friendships, and an exclusive reliance on the group as a source of social life (M. S. Corey, Corey, & Corey, 2014).

Some group leaders set ground rules at the outset that attempt to prohibit or discourage members from socializing outside of group time, and when the rationale is discussed and understood, this can be a useful approach. It is important that members understand that the primary purpose of a group experience is not for members to acquire friendships within the group but rather to teach participants attitudes and skills they can use to form friendships in their everyday lives. Yet friendships cannot be prevented from developing, and if this occurs and affects the group's functioning, it is probably best to have an open discussion in the group so other members can share how they are being affected by these friendships.

Group Counseling for Former Clients

Some counselors form their groups largely from their former clients in individual therapy. They see it as a useful progression to suggest a group experience after a certain number of individual sessions. Such a practice can be useful for a client's growth and, if routinely done in this manner, seems appropriately aimed at maximizing client benefit and minimizing client expenses.

One potential problem that we see, however, is possible jealousy on the part of some clients. When they were seen individually, they had the counselor to themselves for the hour. Now, as group members, they must share their counselor with other group members. This can be therapeutically useful, but it is essential for these clients to discuss their reactions in the group setting. In addition, other group members may perceive the person who has had private therapy with the group leader as someone "special," and this reaction needs to be expressed and dealt with in the group.

When counselors conduct groups composed of their former individual clients, counselors need to remember what each client has said in the group versus what the client may have discussed during individual sessions. This takes some vigilance on the counselor's part. It would be a breach of the group member's confidentiality for the counselor to bring up material that had been discussed only in individual sessions.

Admitting a Friend or Acquaintance to a Counseling Group

Admitting a friend or an acquaintance is a very different matter from admitting a former client to a group. In the latter case, a professional relationship is already established. In the former case, we have the shifting of roles from a personal relationship to a professional relationship, which we think could create many difficulties for the therapist, the friend or acquaintance who becomes a group member, and possibly for others in the group. Again, the bottom line seems to be the importance of predicting potential problems when dual role relationships are being considered and discussing them fully. When there is a shifting of roles, and when this is not explored openly, problems can arise in the group. Hidden agendas will block the flow of group process.

Concurrent Individual and Group Counseling

Are role conflicts inherent in serving as both the client's individual counselor and group counselor? When a client participates with the same counselor in both individual counseling and group counseling, the effects can be therapeutic if both modalities are synchronized and are working well together. There are, however, some potential problems that call for careful consideration. Practitioners who see clients on an individual basis and also in a group should have a clinical justification for this practice. It

would not be ethical to engage in this practice primarily to meet one's own financial or psychological needs. Yet it is possible for the same counselor to work beneficially with the same client on an individual basis and in a group setting. For example, we know a clinical social worker in a community agency who works in individual therapy with women with a history of incest and also offers a short-term support group for incest survivors. She screens members carefully and determines which clients could benefit from concurrent private therapy and participation in a support group. Clients in their individual therapy can explore in more depth certain personal issues that they may not have time to explore in the group. Concurrent individual and group counseling can work well if the counselor has a clear rationale for this form of treatment and if the counselor discusses the possible benefits and risks of this approach.

Another clinical social worker who works in a community agency sees many of his clients on an individual basis. He also refers a number of his male clients to a men's group that he and one of his colleagues conduct in the agency. He finds that working with men in individual sessions initially and then progressing to a group to explore common themes is extremely productive. In this case, it is not a situation of simultaneous individual and group counseling but of individual therapy followed by a group. In many instances, clients can benefit from joining a group after their individual therapy is completed. The continuing support they receive can be helpful in maintaining treatment gains and is usually quite affordable.

We think that, generally, counselors are wise to avoid serving as both individual and group counselor for the same client when this situation can be avoided. Of course, in some treatment facilities, these types of dual roles cannot be avoided. Treatment plans in inpatient settings routinely include individual and group counseling, and sometimes both modalities are provided by the same practitioner. Then it is up to the practitioner to take steps to lessen the possible damaging effects of functioning in multiple roles, especially as this applies to any compromising of confidentiality. Clients have a right to know what disclosures will be kept confidential and what information might be shared with other members of a treatment team.

Perhaps the most justifiable approach to meeting the needs of clients who could benefit from both individual and group counseling is for the services to be provided by different counselors. Many private practitioners, for instance, work with individual clients who are also concurrently attending aftercare groups at hospitals or in the community. When concurrent individual and group counseling are provided by different therapists, the two clinicians should work cooperatively (with the client's permission to communicate with each other) so that the goals of individual counseling and group counseling are understood by all parties. Decisions regarding concurrent individual counseling and group counseling are multifaceted; they are influenced by the setting in which the counseling takes place, by the client's needs, and by the theoretical orientation and preferences of the practitioner.

Limits of Self-Disclosure

When group counselors overextend the boundaries of self-disclosure, this disclosure can create special problems in a group setting. As counselors, if we use the groups we lead to obtain our own therapy, we will create confusing relationships. Are we the leader of the group or merely another member? As leaders, we need to monitor our self-disclosure so that we are aware of what we are sharing and why we are sharing certain personal information. Group leaders need to think carefully about *what, how much,* and *when* to disclose personal reactions in group counseling and develop guidelines to determine what kinds of disclosure are helpful and what kinds might bog down the group.

This vignette reveals Glen's philosophy and practices regarding self-disclosure:

> Glen makes it a practice to be very self-disclosing in the men's groups that he facilitates in a community agency setting. He believes that one of the best ways to facilitate openness on the part of the other men is for him to model disclosure of his past and current difficulties as a man. He is also willing to take time to explore a present concern if it is getting in the way of his being present as a group leader. Although he is a skilled group leader with considerable training, he firmly believes that his own realness is what helps to create a trusting and cohesive group.

- What are your thoughts about Glen's willingness to be personal in these groups?
- Do you see any potential ethical or clinical problems in Glen's self-disclosures about his past difficulties as a man? About his present concerns or personal issues?
- What dual relationship or boundary concerns, if any, do you have in this case?

It is not the role of group leaders to use group time to work through their personal problems; however, leaders can engage in a wide range of other self-disclosing behaviors. With few words, they can let members know that they are personally affected by the members' sharing of problems. Members can benefit from knowing that the group leader can identify with their struggles. Leaders can also express their persistent reactions to members in a nonjudgmental and timely way and offer feedback to members. They can model appropriate and timely self-disclosure by expressing their here-and-now reactions to what is taking place within the group, including how they are being affected by individual members. Disclosure that is related to what is going on in the group can be very productive. For example, any persistent feelings, thoughts, and reactions leaders are having about what is happening (or not happening) are generally best revealed. If leaders sense a general reluctance in the group, it is best to

talk openly about the reluctance. This kind of leader self-disclosure can be quality feedback to the members, and it can facilitate the group process.

At times, the leadership and membership roles in a group may not be crystal clear. However, as group leaders we must not forget our primary role and purpose for being in the group. Our main purpose is to facilitate the self-exploration of others, not to work through our own personal problems. If we become aware of problems, we should consider joining a group in which we do not have leadership responsibilities.

Couples and Family Counseling

As is true for group counseling, boundary issues are often complex when counselors have multiple roles in counseling couples or families. Because of the complexity of their work, couples and family counselors are faced with more potential ethical conflicts than are practitioners who specialize in individual therapy. Because most couples and family counselors focus on the family system as the client rather than on the individual's dynamics, ethical dilemmas can arise in the first session. Under the family systems model, counselors avoid becoming agents of any one family member, believing that all family members contribute to the problems of the entire family. Ethical practice demands that counselors be clear at the beginning of the therapeutic relationship about their commitments and responsibilities to each member of the family.

Counselors who work with couples often encounter ethical dilemmas that involve serving one person's best interest at the expense of the partner's interest. This is especially true when the partners do not have a common purpose for seeking counseling. How do counselors carry out their ethical responsibilities when one partner comes for divorce counseling and the other has the expectation of working to improve the marriage? It can be especially challenging to address this conflict when the motivations of one or both partners for participating in couples counseling are part of a hidden agenda. Another potential dilemma arises when counselors adopt multiple roles, providing individual therapy to one or both parties while simultaneously treating the couple. Although this can be a very effective treatment strategy, the counselor will need to consider both the benefits and risks of this approach.

Defining boundaries, clarifying the therapeutic goals, and managing multiple roles and relationships are particularly important in couples and family counseling. Questions that provide a framework for our discussion here include the following:

- What unique boundary issues arise in couples and family counseling?
- Are role conflicts inherent in counseling a couple while seeing each of the partners individually?
- Are role conflicts inherent in counseling an individual family member and the entire family?

- Are role conflicts inherent in working with a couple while also working with the entire family?

Special Considerations for Couples and Family Counseling

As we have mentioned, some boundary issues apply in a special way in couples and family therapy. A counselor's loss of boundaries in couples or family counseling can create inappropriate alliances and render the therapy ineffective. Although these concerns also exist when providing individual counseling, couples and family therapy requires that the clinician develop rapport, maintain alliances, and facilitate communication among all involved while continuously monitoring and managing his or her own roles and boundaries.

Consider this example:

> Paul, an intern, was counseling a couple who came to therapy to work out problems in their marriage. Paul increasingly came to view the wife as overbearing and rigid. As the supervisor observed a session, she noted that Paul's responses to the husband were generally supportive, whereas his responses to the wife's verbalizations were often challenging or nonempathic. When the supervisor met with Paul and asked him what he was experiencing in the session, Paul replied, "I don't see how he can stand being married to her!"

In this example, Paul colluded with the husband, in effect lining up with him against the wife. If you were Paul's supervisor, how might you work with Paul? Might you point out that Paul had created an implicit and unacknowledged dual relationship as the husband's defender and advocate?

Dual relationships can arise for marriage and family therapists in other, more obvious ways. When the therapist has a prior relationship with either a husband or a wife, or with one member of a family, marriage and family therapists recognize the inadvisability of entering into a counseling relationship with the couple or the family. Social relationships with couples or families who are currently in counseling are generally to be avoided. When an individual has been in counseling, and then wishes to change the focus of the counseling to marriage or family therapy, some therapists refer the case to another professional. The prior individual therapeutic relationship might present some difficulties for the newly entering spouse or family members, who might not feel on an equal footing.

In marital and family practice, a counselor might see a wife in individual counseling, and then at some point the husband might join the sessions for couples counseling, and at times the entire family might be seen. Some therapists may not be comfortable with this practice, and they may have difficulty sorting out primary allegiances. In particular, confidentiality questions are likely to arise, and counselors need to be clear about their policies regarding secrets and hidden agendas.

Systems theory is based on a different orientation than individual therapy. In doing individual counseling, we may be sensitive to how an individual's changes affect his or her family, and we may explore ways in which the client's family is now influencing him or her, but the primary focus is on the individual's dynamics. From a systems perspective, one part of the system affects the whole system, and the system affects the individual. Margolin (1982) argues that complex dilemmas can arise when family members are seen together in therapy. Some interventions that serve one person's best interests might burden another family member or even be countertherapeutic. Family counselors need to make intricate judgment calls in attempting to balance their therapeutic responsibilities toward individual family members and toward the family as a whole.

To be able to work ethically with couples and families, it is critical that practitioners have made a paradigm shift from an individual perspective to a systemic way of thinking. Many mental health providers have been trained to deliver individual psychotherapy, and it is not clear how many of them are competent in making interventions from a systemic perspective (Harway, Kadin, Gottlieb, Nutt, & Celano, 2012).

A Contributor's Perspective

In the following section, Amy Manfrini, a marriage and family therapist in private practice, addresses boundary issues of special significance to working with couples and families.

Boundary Considerations in Counseling Couples and Families

Amy Manfrini

Boundaries play a central role in all counseling relationships in part because of the differential power relationship between therapist and client. As a practicing marriage and family therapist for more than 25 years, I have observed the important and powerful role that boundaries play in a clinical setting.

People often enter treatment in a state of disorganization, feeling vulnerable and fragile. Clients will relinquish some of their own authority, allowing the therapist to be very influential in their lives. As a marital and family therapist, my goal is to establish and maintain a healthy working alliance rather than one of power or control. It is critical that I clearly define the nature and limits for therapy from the outset of a professional relationship.

Couples and families in treatment are often already struggling with boundary concerns and experiencing chaos in their own relationships, making it especially important that I be clear in the description and parameters of the therapy relationship. I don't want to compound their situation, or increase their confusion, by setting poor boundaries myself.

Conversely, being too rigid can cause the therapeutic environment to feel cold and uninviting. Clients need to experience therapy as a safe and secure place where they are supported and encouraged to take risks. I strive for a good balance between being warm, caring, and authentic, yet professional. Boundaries initially are set by clearly conveying my professional role at the initial session. Overall, ethical guidelines regarding boundaries are similar across client groups. When treating couples and families, however, it is important to consider these additional factors regarding boundaries:

- *Defining the client:* Who will be the focus of treatment? What boundary issues should be considered in couples and family therapy when making this decision? Can this change?
- *Avoiding alignment and collusion*: How do I prevent crossing or violating boundaries with one particular member of a couple or family? What should I do to avoid this?
- *Using self-disclosure*: When do I disclose personal information about myself with couples and families, and for what purpose?

Defining the Client

The first decision to make as a marriage and family therapist is who will be the focus of treatment. I begin to consider this as early as the initial phone call. When presenting problems involve couples or family issues, I prefer to see everybody in the relationship for the intake assessment. This allows me to evaluate more accurately whether it will be an individual, couples, or family therapy case. Who my client or clients will be is actually my first boundary consideration. It is important to decide and clearly define, from the beginning of the therapeutic relationship, who is the focus of treatment. Failure to do so can result in a poorly defined professional relationship and may later cause confusion for everybody. Consider this scenario:

> In an initial phone call, a distraught wife asking for marriage counseling requests that I meet with her individually for the first session. She wants to share private information regarding her husband and facts about his recent extramarital affair. I let her know that this is actually a fairly common request from new clients, and that although it may be more comfortable for her to share this without him being present, I prefer to meet with them together for the initial assessment, as well as for subsequent sessions.

Because I describe my boundaries prior to beginning treatment, this potential client understands where my focus will be and can make an informed decision about selecting me as a therapist.

Sometimes individual treatment, as well as couples or family therapy, is required. Several issues and needs might be identified, leaving the therapist to decide whether to treat only the couple or family or also to provide

individual therapy separately. In my own practice, I lean toward treating couples and families as a unit whenever possible rather than seeing any of them individually at the same time. There are times, however, when seeing family members separately, individually or in subgroups, such as siblings together, is beneficial to treatment. This decision should include careful consideration of benefits, risks, treatment goals, and ethical concerns.

Sometimes a therapist may decide to work with a child individually once family therapy has been completed or to switch to couples therapy following individual treatment with one of the partners. The challenge is to make a clinically sound decision to switch modalities. If the therapist repeatedly switches back and forth between treating the relationship and one or more individuals, it can become confusing, counterproductive to treatment, and even harmful to clients. The focus of treatment should be clear at all times, and a clinically sound rationale should guide the decision to transition. Each case should be considered separately and any risks weighed carefully. The decision should be made collaboratively with the clients, informing them of any ramifications that can be foreseen. It is very important to be proactive and openly address what each client might experience and what concerns he or she may have. This helps redefine clear boundaries around who the client is and reduces the risk of later confusion.

There is no standard rule that dictates how a therapist should make the sometimes difficult decision regarding whom to treat. What informs my decision to see people together primarily is my belief that people's relationships are the most important aspects of their lives. Children want to feel good in their families, and partners want to be fulfilled in their marriages and relationships. I prefer a relationship-oriented and experiential approach in which people change the way they operate together, or relate to one another, within our sessions. Many therapists do, however, see people both together and separately. Each case is unique, and the personal approach to treatment will depend on therapists' theoretical orientations, clinical models they utilize in working with clients, and their own personal comfort level using different strategies with couples and families.

The therapist who is the sole provider of treatment for members of a family or couple together and separately has the advantage of having all the information regarding each member of the couple or family available for evaluation. Thus treatment goals can be designed to be congruent, compatible, and easily monitored. Another advantage is that clients are generally secure when one therapist provides all of their treatment and often are clearer about what to expect. They may feel less fragmented and less overwhelmed when only one person manages their case. With such an arrangement, there is less chance of having conflicting treatment goals for each case. An example of such a conflict would be a husband participating in individual therapy with his own therapist while he and his wife engage in couples treatment with a different therapist. Goals set in his personal therapy may be incongruent or in conflict with those of the

marital therapy. This is an important consideration when deciding how to proceed when both couples and individual treatment are necessary.

Other important factors to consider when deciding to treat one or both individuals separately while continuing to work with them together include managing multiple roles while maintaining trust and a strong therapeutic alliance with both parties. Therapists should have a solid clinical basis for seeing people separately and as a couple simultaneously. Benefits and risks should be thoroughly discussed with clients and include a clear policy regarding confidentiality. Because therapists may gain additional and possibly sensitive information when seeing people separately, it is important to factor in potential ethical pitfalls.

This is often covered in the informed consent process and may include client permission and formal consent for the therapist to share information between both parties if it is important in furthering the goals of couples treatment. This allows the therapist to maintain confidentiality while avoiding becoming a keeper of secrets that could compromise trust and the integrity of treatment. From the onset of this arrangement I outline clearly with my clients the reasons I will be seeing them together and separately, how this will be beneficial to them as a couple in treatment, potential risks, and specifically what steps I will take if I receive information divulged to me in confidence that I deem important to share.

Theoretically, having one therapist as the sole provider can be very valuable as long as clear and healthy boundaries are maintained, but it is important to remember that, practically speaking, this is a demanding task. I generally work with couples in conjoint sessions and will usually refer to other therapists to provide any necessary individual treatment. A benefit for me is that I am able to specifically keep my focus of treatment on the relationship itself. My preference in my practice is also to work with couples and families from more of an experiential approach in the context of the relationship, but when the best treatment plan involves meeting separately in addition to jointly, it is very important to remember that remaining clearly focused on a couple or family while treating members separately requires remarkable insight and awareness to avoid becoming overly attached to or aligned with a particular individual. The counselor needs to be objective and attentive to the needs of all parties at all times to coordinate treatment effectively and continuously assess and monitor the needs of all to maintain trust and a strong working alliance.

When working with a couple, for instance, if I receive information during a separate session with one of the parties that I have been asked to keep confidential, I will need to weigh all important factors. Although I have received prior consent to share anything pertinent with the other party, I am now in a sensitive and difficult position. If I believe it is important that the information be shared in the best interest of the couples treatment, I must carefully consider such possible ethical and treatment ramifications as holding a secret, breaching a privacy, compromising trust, or

undermining the best interest and treatment of the couple. A final concern involves possible premature termination of a case due to complications resulting from multiple role issues. This would be a decision made only after careful consideration and one that could be difficult for all parties.

Other challenges include maintaining equal rapport with each separate client while keeping a solid and equally supportive relationship with the couple or family. Clients may perceive me as more devoted to the needs of their partner or another family member than to the relationship itself. If my focus becomes unclear, I may become more invested in one particular person, which would result in a conflict of interest.

These concerns are very difficult to predict or to control. Although safeguards such as informed consent can help, they may not prevent serious boundary crossings, violations, or ethical dilemmas. This not only risks the integrity of the therapy relationship but can seriously undermine treatment. Therapists should be cautious and examine the risks to treatment when deciding what method to use. Consider this scenario:

> While working with a couple on communication and intimacy issues, I also agree to treat the wife individually for depression stemming from childhood abuse and explore how this impairs her ability to be close to her husband. I witness her emotional struggle and hard work in individual sessions week after week. Although the husband is aware of her past, he remains frustrated in our couples sessions because things aren't improving more quickly.

Because I witness the wife's struggle, I may tend toward nurturing, supporting, or even defending her in the couples sessions. This would constitute a boundary crossing with serious clinical ramifications. I am blurring my professional role as a therapist with her and assuming a protective position. This is counterproductive to her therapy and undermines her role as an adult. It would undoubtedly damage my rapport with the husband and probably would lead to trust issues, which would undermine the couples sessions. The end results would most likely include confused and frustrated clients, harm to the therapeutic relationship, and poor counseling outcomes.

Another reason I would rather treat couples jointly is based on my view that growth in marriages and partnerships occurs most powerfully within the relationship itself. I believe that very powerful and productive individual therapy can often occur within the context of joint sessions, meeting the needs of the individuals as well as those of the relationship. One key advantage of seeing people together is that what happens in the session can be directly observed. Rather than simply hearing about how they view themselves as a couple, the therapist can ask them to talk directly to each other. This method fosters increased intimacy and understanding between partners and adds a powerful dimension to the therapy. In cases where couples are not able to work within such an intimate context, for

whatever reasons, I might refer them for adjunct treatment with separate therapists. When possible, I then would work collaboratively with the other involved therapists to share treatment goals, discuss progress, and avoid conflicting or opposing therapeutic agendas for our clients.

My practice when treating families is to see all members together for at least part of each session. This reinforces the boundary around the whole family as the focus of treatment and keeps the primary emphasis on the family as a whole. Often it is clinically helpful to split families into subgroups, or smaller configurations such as parents, siblings, older or younger children, biological or step-family members, brothers, or sisters for some work. Subgroup work can help families establish or redefine unclear or unhealthy boundaries between or among them, as this example shows:

> While treating a recently divorced single father and his two elementary school-aged children for adjustment issues, it became apparent to me that both children were very worried about their father. They described him as "sad and lonely." The children appeared to feel responsible for "making him feel better." One of my treatment goals was to assist the father in his adjustment as a single parent, empowering him in this role while also providing him with support. This removed the responsibility from his children, allowing them instead to explore some of their own age-appropriate adjustment issues to their new circumstances. Each week, I met with the three of them for a few minutes, and then I split them into parent/sibling subgroups. By doing this, I was able to provide the children with time to process feelings and thoughts regarding their experience as children of divorce and assist their father in gaining confidence and adjusting to his new role, while remaining focused on the well-being of their newly configured family unit of three.

When splitting families into subgroups, it is important to explain the process. Children might want opportunities to talk freely without parents present, and parents may need time to discuss parenting or marital issues without children present. My experience is that parents and children usually respond well to the idea of subgroup work, and improvements in the family often emerge as a result of having clear and healthier boundaries reestablished in the therapy setting.

Discussing rules about sharing information outside of counseling is also important. Setting guidelines for communicating once everybody leaves and for continuing discussions at home can be addressed in an effort to keep the therapeutic environment a safe and productive place. This speaks to the importance of clarifying relationships both in and outside of therapy.

Avoiding Alignment and Collusion

Another threat to clear boundaries when working with couples and families is becoming aligned or colluding with a particular individual rather

than keeping the relationship the focal point of treatment. Just like individual therapists, relationship therapists can find themselves feeling especially connected or attached to a particular person. It is common to experience strong feelings such as sympathy, frustration, or even anger toward clients. This often occurs unconsciously. We are trained as counselors to be self-aware, regulating and monitoring our countertransference responses. Alignment or collusion is similar and requires the same degree of personal insight on the therapist's part. When regularly working with two or more people in their marriage or family, therapists are likely to have different feelings toward each client. Couples and family therapists need to stay equally focused on the concerns of each client in the relationship and avoid putting their own feelings or needs above those of the couple or family.

Working with a family where both parents are disengaged from a child who presents with depression might elicit strong feelings of sadness from me. I may find myself sympathetic and be tempted to align with and nurture the child. An empathic response here would be normal and therapeutically healthy on my part, but alignment with the child would be clinically inappropriate. If I were to act as the child's rescuer, I would blur the therapeutic boundaries and impair my professional judgment. I should, instead, maintain clear professional limits while addressing the disengagement in this family. I can remain warm and supportive to all family members while providing information and education that will help the parents to assume a more nurturing role with their child.

Using Self-Disclosure

A general guideline regarding therapist self-disclosure is that it should be used to benefit the therapeutic relationship or treatment process. A risk is that self-disclosure can change or distort the boundaries in therapy, complicating treatment. As opposed to being something to avoid, however, I believe that revealing personal information can be very helpful when used appropriately. I am mainly concerned about *when* and *how* to make personal disclosures to clients. It is essential that my disclosures are always done to benefit the client. In the early stages of treatment, developing rapport with new clients can be enhanced through the selective use of self-disclosure.

When working with children in family therapy, I might compliment a child on her shoes, telling her I have a daughter who likes them as well. This can encourage more conversation and allow us to develop a friendly, easy rapport. Validating a client's experience and conveying empathy can also be an appropriate use of self-disclosure, which can normalize an experience when a client feels isolated or alone.

Families and couples often present similar complaints. Issues of balancing responsibilities, managing finances, parenting styles, communication patterns, and emotional or physical intimacy are common presenting

problems in relationships. When two parents work outside the home and struggle with juggling household and child care responsibilities, I often have shared that my husband and I also have faced these demands. In a family where parenting styles differ, I might disclose that most parents, including my husband and myself, bring different strengths and weaknesses to the table, resulting in parenting conflicts.

Disclosure can benefit treatment, but it can also hinder the process and threaten therapeutic boundaries. Timing, frequency, content, and rationale are all aspects to consider but remain at the discretion of the therapist. When and what to share is a subjective decision. I don't disclose often, nor do I usually disclose deeply personal information. If clients ask for personal information, I consider the length and nature of our working alliance, their ego strength, and the purpose for their interest. Sometimes they simply want to know they aren't alone, or that their situation is not hopeless. Often they need another point of reference. However, at other times clients may simply be curious or want to learn more about me, and this is something that needs to be explored in the therapeutic process.

Questions for Reflection

Some considerations unique to boundaries with couples and families in therapy include identifying the client; keeping the definition of the therapeutic relationship clear; and maintaining a treatment environment that is safe, caring, and productive. My ability to establish and maintain limits in my personal life and interpersonal relationships will affect my ability to do so in my clinical work. Professionals who have boundary issues with interpersonal relationships will likely have difficulties establishing and maintaining appropriate limits with clients. It is useful to explore the following questions when considering your own role in couples or family counseling:

- How were the boundaries in your own family of origin defined? How did this early experience in relationships shape the way you establish and maintain boundaries in your current personal relationships?
- What are your tendencies in your own marriage, or partnership, as they relate to role definitions and boundaries? How might your experience with your significant other influence your expectations regarding roles and boundaries with couples you treat in therapy?
- When working with families in therapy, what potential issues may you need to address pertaining to roles and boundaries, and what areas do you need to further explore to help you set clear and useful boundaries with your clients?

It is of paramount importance that we remain insightful and aware, remembering that clients rely on the therapeutic relationship to be supportive. If we do not recognize the importance of boundaries, or know

how to set and maintain them, we invite poor counseling results and in worst case scenarios can do harm.

Clear and clinically sound rules, roles, and limits should be set from the very beginning of treatment and monitored and maintained throughout the course of the professional relationship. Because couples and families often enter therapy confused in their own relationships, and face the additional tasks of disclosure and confrontation of loved ones within the therapy context, clarity and safety are particularly important. Keep your clinical position clear, but allow your personal strengths to help create an environment and relationship conducive to growth. Be warm and empathic while also remaining professional and competent. Be cautious about decisions to provide family or marital therapy while also treating the same people in individual therapy, and use personal disclosure wisely.

Through many years of practice, I have come to depend upon these guidelines when working with couples and families. Regardless of what guiding principles you adopt in your own work, considering and respecting their function and importance in the treatment process is imperative.

Conclusions

Boundary issues are fraught with complexities when counselors work with multiple clients, both in a group format and in couples or family counseling. In group counseling, questions arise regarding personal and social relationships with group members, admitting former individual clients or friends into groups, providing both individual and group counseling to the same client, and group leader self-disclosure. Couples and family counselors must be alert to potential role conflicts as well. Amy Manfrini offered a practitioner's perspective on how to best manage these conflicts in counseling couples and families.

Chapter 9

Boundary Issues in School Counseling

In this chapter, we look at dual or multiple relationship dilemmas that occur in the school setting. A. Michael Dougherty, Russ Curtis, and Phyllis Robertson identify some roles and duties commonly assumed by school counselors that can create dual relationship conflicts. Catherine Geoghegan McDermott addresses a counselor's boundaries with teachers, administrators, and parents, and Kellie Giorgio Camelford writes about the challenges school counselors face in dealing with social media.

School Counseling

School counselors need to be aware of the dual relationship conflicts they are apt to encounter in their work. These conflicts can arise in subtle and sometimes unexpected ways for school counselors. Four standards in the *Ethical Standards for School Counselors* (American School Counselor Association [ASCA], 2010) address dual relationships:

> A.4. Professional school counselors:
>
> a. Avoid dual relationships that might impair their objectivity and increase the risk of harm to students (*e.g.*, counseling one's family members or the children of close friends or associates). If a dual relationship is unavoidable, the school counselor is responsible for taking action to eliminate or reduce the potential for harm to the student through use of safeguards, which might include informed consent, consultation, supervision and documentation.
> b. Maintain appropriate professional distance with students at all times.
> c. Avoid dual relationships with students through communication mediums such as social networking sites.
> d. Avoid dual relationships with school personnel that might infringe on the integrity of the school counselor/student relationship.

Consider these two scenarios involving Wayne and Angelica, both school counselors:

- After school a teacher drops by Wayne's office. Wayne and the teacher are friends. Wayne casually asks, "How's it going?" The teacher's response comes out in a rush. She is feeling tremendously stressed by the demands of raising a child with a handicapping condition, caring for an aging parent, and going to graduate school. When Wayne suggests that she might want to consider seeking counseling, the teacher says, "Where on earth would I find the time or money for that! I hope you won't mind if I just 'bend your ear.'"
- Angelica is conducting a parenting skills group one evening per week. During the fourth session, one of the parents relates an anecdote about the discipline methods he uses. It seems clear to Angelica that these methods are physically abusive.

These two situations seem quite dissimilar, but they both raise potential dual relationship conflicts. In Wayne's case, the teacher clearly needs a "listening ear" and perhaps is hoping to receive some free counseling. It might be relatively easy for Wayne to convince himself that it is okay just to listen occasionally in his office after school and that it is his job to serve the teachers as well as the students. Yet Wayne's friendship with the teacher prohibits him from entering into a counseling relationship.

Angelica, too, might be torn by conflicting wishes. Although she knows she is legally and ethically required to report the child abuse, she foresees the difficulty in attempting to serve both as the ongoing group leader and as the reporter of the abuse. She does not want to destroy the parent's trust and perhaps disrupt the group. She is tempted to avoid or postpone reporting in the hope that the parent will learn nonabusive discipline methods by continuing in the group.

- If you were in Wayne's place, what might you do?
- How might you respond to your friend's request in a way that both preserves the friendship and assists her in getting the help she needs?
- What might you do if you were Angelica?
- How could you best balance the requirements of the law, the needs of the child, the needs of the parent, and the needs of the group?

The situation in which Wayne finds himself, in the first scenario, is not at all uncommon. Friendships between teachers and school counselors are a natural outgrowth of their similar interests and daily contacts. In addition, many school counselors were teachers before they became counselors, and sometimes they counsel in the same school where they taught. When the transition first occurs from teacher to counselor, difficulties can arise. Teachers who are accustomed to the open sharing that takes place

among colleagues may resent that the counselor, in his or her new role, has a different perspective on student concerns and is less forthcoming with certain kinds of information because of the need to protect student confidentiality. These transitional difficulties can probably best be resolved through open communication in which the counselor clearly defines and explains the rationale that guides decisions in her or his new role.

Another problem relates to school counselors who are also still teachers. Can they balance both roles? Being a teacher might help the counselor to better understand students, yet the teacher role could get in the way of forming the counseling relationship. When a professional must serve simultaneously as a teacher and a counselor, every effort should be made to have a caseload of counselees who are not taking classes taught by the teacher/counselor.

School counselors often will have friends who are also parents. When a friend's child attends the counselor's school and is assigned as a counselee, an uncomfortable dual role conflict may develop. The counselor must maintain clear boundaries around the professional relationship with the child and the personal relationship with the child's parents, which can be a difficult task.

Particularly in small towns and rural communities, it is difficult for school counselors to avoid some overlap between their personal and professional lives. When the counselor's friends are also the parents or teachers of the counselor's student clients, some role conflicts may be inevitable. For example, Gerald and Marianne Corey once consulted with school counselors in Alaska who are assigned to several schools in remote villages often accessible only by airplane. The counselors serve many schools, often perform many functions, and are sometimes even relatives of some of the schoolchildren. This example reminds us that the dual relationship issues pertaining to school counseling need to be considered within the context of the community.

Increasingly, school counselors are being called upon to serve in multiple roles, including the roles of school leader, advocate, collaborator, and agent of systematic change (ASCA, 2012), and to serve multiple constituencies. ASCA's *Ethical Standards for School Counselors* (2010) spells out the counselor's responsibilities to students, parents, colleagues and professional associates, school and community, self, and the profession. When school counselors try to balance their responsibilities to students with their responsibilities to parents, conflicts can arise, particularly around confidentiality issues. Counselors are legally responsible to the parents but ethically more responsible to the students. Minor clients have a right to know what information they reveal to their counselors will be kept secret and what might be shared with parents (or teachers or administrators). The meaning and the limits of confidentiality need to be explained to students in a way they can understand. One way to lessen the impact of some role conflicts is to

conduct sessions with the student and parents in those situations when the parent wants information about the child.

School counselors are often faced with ethical dilemmas if their roles are not clearly defined, or if school policies exist that impinge on their effectiveness. To whom does the school counselor owe primary allegiance—the student, the student's parents, the school, or the community? ASCA (2010) provides guidance on this question:

> [School counselors] recognize their primary obligation for confidentiality is to the students but balance that obligation with an understanding of parents'/guardians' legal and inherent rights to be the guiding voice in their children's lives, especially in value-laden issues. [School counselors] understand the need to balance students' ethical rights to make choices, their capacity to give consent or assent and parental or familial legal rights and responsibilities to protect these students and make decisions on their behalf. (A.2.d.)

If counselors are expected to carry out disciplinary functions, their capacity to serve as effective personal counselors is severely restricted. If they are expected to report student drug use to parents or administrators, this will affect their ability to form counseling relationships with many students. If counselors are required to inform parents about details in cases concerning birth control or abortion, some students may avoid their counselors. Sometimes school counselors are asked to monitor tardiness or truancy, police the restrooms or cafeteria, enforce school policies, or supervise school events. Carrying out duties associated with any of these roles can make it more difficult for counselors to establish personal counseling relationships with students.

The School Counselor as Consultant

School counselors are increasingly being expected to serve as consultants to teachers, administrators, parents, and community resources. This can create role conflicts. The counselor role assumes that the counselor's primary function is to establish a therapeutic relationship with the student's welfare as the primary consideration. The consultant role, in contrast, emphasizes the process of working with other professionals when this is in the interest of the client. Ferris and Linville (1985) raise some important questions about these conflicting goals: How can counselors uphold their responsibility for the student's best interest if they are working only indirectly with the student in a consultant role? What are the ethical implications of giving a measure of responsibility for intervention and treatment to consultees (parents, teachers) who are not trained as counselors?

Consulting is not the same as counseling, and the two roles should be kept separate. In their role as consultants, school counselors are most likely to encounter ethical issues pertaining to dual relationships when

they are involved in situations in which boundaries are not clearly drawn. Being aware of the issues involved in the consultant/consultee/client relationship, and the rights of consultees, can enable counselors to identify and deal with ethical problems that arise. School counselors who function as consultants need to develop a well-defined set of mutually agreed expectations regarding the nature of consultation. As A. Michael Dougherty noted in Chapter 6, the consultant's focus must be on work-related concerns. School counselors should avoid discussing the personal concerns of a teacher or an administrator during consultation with that person. Acting as consultants, school counselors need to avoid their tendency to move toward exploring the personal problems of their consultees and monitor their interventions so that they avoid creating dependency, using manipulation, or misusing power. Consultants should strive to maintain a collaborative relationship with their consultees.

Dealing With Child Abuse

Perhaps no arena has more potential for dual role conflicts than child abuse. When counselors become aware of situations involving suspected child abuse or neglect, they are required to report it. The school counselor's role, however, is rarely limited to making a report. Remley and Fry (1993) note that school counselors are often asked to perform a multitude of functions—including informant, counselor to the victim or perpetrator, school system employee, court witness, liaison with social services, and counselor to the family—that involve distinct and conflicting roles. These authors point out several conflicts that can arise.

The counseling relationship with the child may be endangered when a counselor files a report. A child may have conflicting reactions when the counselor reports the abuse. The counselor may be seen as an ally in putting a stop to the abuse, or the child may feel betrayed and angry, particularly if retribution occurs in the home or if the child is removed from the home and perhaps from the school as a result of the counselor's action. Most abused children are left in their parents' custody, and the counselor may then be involved in providing ongoing counseling to the child. Treatment of abuse victims can be a lengthy process that severely strains the counselor's resources. A problem can also develop if the counselor does not maintain appropriate boundaries. For instance, some counselors may be tempted to befriend such children or even attempt to "adopt" them. Counselors need to recognize their limits and not allow themselves to become overly involved to the extent that they lose their capacity for objectivity.

Counselors also need to follow procedures that have been established in their school systems. Some systems require that the principal be notified before a report is made, and some systems require that teachers be informed. It is difficult to maintain confidentiality in these instances.

Once a counselor has made a report, he or she may be involved with the court system until adjudication is made. The counselor will need to work with Child Protective Services caseworkers, the police, and perhaps attorneys. If the case goes to trial, the counselor may be required to testify as a witness. The multiple roles played by the school counselor involved in a child abuse case can severely test the counselor's ability to handle conflicting demands and keep the client's welfare foremost.

Clarifying the School Counselor's Role

According to Glosoff and Pate (2002), school counselors need to balance their ethical and legal responsibilities to the students they serve, to the parents or guardians, and to the school system. Because school counselors are part of an educational community, they often consult with parents, teachers, and administrators. During these consultations, school counselors need to make clear that their primary client is the student (Glosoff & Pate, 2002).

A Contributor's Perspective

A. Michael Dougherty, Russ Curtis, and Phyllis Robertson believe that school counselors should avoid roles that conflict with their primary role as counselor. They offer counselors some strategies for taking a proactive stance in defining their roles.

Managing Role Conflicts in School Counseling

A. Michael Dougherty, Russ Curtis, and Phyllis Robertson

School counselors often are asked as part of their everyday duties to take on roles that might conflict with their primary role as counselors. We discuss four areas in the practice of school counseling that can easily have boundary issues related to them: disciplinarian, advocate, consultant, and private practitioner. School counselors serve as leaders, advocates, and team members within the school environment to remove barriers and promote the success of all students (ASCA, 2005, 2012). We believe school counselors should avoid roles such as disciplinarian, substitute teacher, or lunchroom/bathroom/bus monitor that conflict with their primary role as counselors to students. The unique role of the counselor in the school makes the assumption of such roles highly questionable, and assuming them is likely to violate some of the basic tenets of the counseling relationship (such as confidentiality). As a consequence, new counseling relationships with students may be inhibited and existing ones may be compromised. Therefore, as we will illustrate, it is incumbent upon school counselors, while remaining team players in the school, to ensure that all stakeholders understand the advocacy role of counselors and how that role is potentially diminished by the aforementioned conflicting roles.

School counselors engage in both preventive and remedial efforts as part of a comprehensive developmental counseling program. Preventive aspects of the program include classroom guidance; consultation and collaboration with teachers, parents, and administrators; advocacy; and membership on student support teams. The primary elements of the remedial role of the counselor include crisis counseling, individual and group counseling, and making referrals for community services.

Emphasis on the preventive aspects of the school counselor's role has increased during the past two decades. Preventive interventions frequently assume an acceptance of the school counselor by other staff persons as "one of us." Counselors are expected to perform their fair share of responsibilities in alignment with those provided by other educators (ASCA, 2005). Unfortunately, many of these activities jeopardize the counseling role of the school counselor. A critical issue for school counselors, then, is how to gain acceptance by staff and at the same time avoid engaging in roles that may have a negative impact on their counseling relationships with students. It may be tempting for school counselors to give in and take on roles such as bus duty, lunchroom duty, or bathroom monitoring, particularly when there is strong pressure from administrators and teachers for them to do so. These dual roles, even when entered into only briefly, certainly put a counselor in a conflict-of-interest situation by creating boundary issues.

As part of our preparation for this piece, we interviewed school counselors at each level (elementary, middle, and high school) to determine what they believed to be the most problematic boundary issues they regularly experience. The obvious theme that emerged from these conversations was their struggle with being a counselor and at times serving in a disciplinarian role. Most of the counselors mentioned having administrative duties that often led to having to enforce disciplinary measures. Discipline ranged from relatively minor events such as serving lunch duty and having to address problematic behavior (i.e., throwing food, yelling) to assuming an administrative role and having to intervene in student fights and address issues related to cheating.

Phyllis Robertson, who was a middle school counselor for 15 years before teaching in a counselor education program, describes the following situation while working as a school counselor.

> As a middle school counselor I conducted counseling groups for children of divorce. Mack was a student in one of those groups. One day I was approached by the assistant principal to serve as a witness to a book bag search of Mack because it was reported that he had brought drugs to school. No other administrator was available at the time, and the assistant principal knew the student was having difficulty adjusting to changes at home. In an effort to be supportive of both the student and the administrative need, I agreed to be present. Illegal drugs were found in the student's possession,

and authorities were contacted. Fortunately, I was able to meet with Mack's parents and provided them with referral information on substance abuse counseling.

This example points out the necessity for caution on the part of school counselors in taking potentially conflicting roles with the students they counsel. By witnessing the search, the counselor could seriously damage the counseling relationship and the student's ability to trust other counselors. Students may hear of this counselor who "asks you to trust her at one time and gets you in trouble another time," and this could keep prospective clients from seeking out the counselor. In this instance, the counselor had to weigh the consequences of serving as a student advocate and as a monitor of appropriate student behavior. School counselors can be "significant contributors to interventions through which problem behaviors are managed and positive behaviors are nurtured" (ASCA, 2007). Witnessing or enforcing a disciplinary action can leave a counselor uncertain as to the role she should perform and always must be weighed with sound reason on what is best for the student. This is especially true in elementary schools, where school counselors are oftentimes seen as leaders of the school when the only administrator is off campus.

At the outset of each school year, school counselors need to complete program service agreements with administrators that can be used to clearly and publicly state their roles to school personnel and parents as well as to students (ASCA, 2005). When staff and students understand the counselor's unique role in the school, potentially harmful dual relationships with students can be avoided. At the same time, school counselors can be accepted as "family" by staff if they take on additional duties that are less likely to create the potential for inappropriate dual relationships, such as working in the concession stand, running after-school parent groups, or conducting professional development activities.

A second potential boundary issue for some school counselors involves the dynamic tension between school counselors' responsibilities to colleagues, professional associates, and the school and their responsibilities related to multicultural and social justice advocacy and leadership. At first glance this would not appear to be an issue. But if we consider the school counselor's function as an advocate and leader in the school regarding the establishment of equal opportunities for all students to achieve their academic goals and the school counselor's responsibilities to other professionals, the school, and communities, the dynamic tension becomes more obvious. Consider, for example, a school counselor who notes conditions in the school that do not reflect equal opportunity for all students. At the same time the school counselor is charged with following school policy in reporting these conditions. All of this sounds simple enough, but if school administrators are not responsive, does the counselor become even more of an advocate? How does the school counselor assess his or her objectiv-

ity in the situation? What if the counselor "gives up" and takes consolation that the condition was appropriately reported? Most likely, issues like these led ASCA (2010) to include the following statement in its ethical standards to assist counselors in dealing with boundary issues such as the one just described:

> When school counselors are forced to work in situations or abide by policies that do not reflect the ethics of the profession, the school counselor works responsibly through correct channels to try and remedy the condition. (G.2.)

A third potential role that can easily have boundary issues is that of consultant. Consultation as a responsive service provided by school counselors is increasing dramatically in light of federal legislation affecting education and the increased importance being placed on school professionals working together to assist students. Consultation is a service provided by a school counselor in a problem-solving format to a consultee (typically a teacher, administrator, or parent) with the goal of helping a student or group of students academically or behaviorally (Dougherty, 2014). The consultant assists the student or students *indirectly* through the intermediary of the consultee, who provides *direct* assistance to the student(s). So instead of counseling a student directly, the school counselor as consultant indirectly positively affects students by assisting the consultee to work more effectively with them. The potential boundary issue becomes one of determining the amount of time spent in consultative relationships with the significant others of students relative to the time spent counseling students directly. Every school is unique, so the school counselor and other decision makers regarding the school counselor's role should make informed, data-based decisions regarding the approximate time the counselor should spend in both direct and indirect service.

Finally, in recent years there has been an increased emphasis on licensure for counselors, and it is now quite common in many states for school counselors to be licensed to conduct private practice. This trend has created the potential for a problematic dual relationship unique to school counselors. Consider the following scenario:

> Leon, a practicing school counselor, is also a licensed professional counselor. One of Leon's specialty areas is family counseling. He maintains a small private practice and counsels with families during the evenings and on weekends. One of Leon's clients at school is Gilbert, a student with attention-deficit/hyperactivity disorder. Leon counsels with Gilbert at school on a regular basis. Gilbert's parents approach Leon about the possibility of him providing family counseling services.

Leon faces several potential ethical problems if he agrees to counsel the family. It is ethically questionable for a school counselor to use his

position to acquire monetary gain outside the school setting (ASCA, 2010). In addition, relationship boundary issues could arise. Both Leon and Gilbert will be placed in dual roles: Leon, as school counselor to Gilbert as an individual and as family counselor to Gilbert's family, and Gilbert, as a student being counseled and as a family member in counseling. What if the parents, during family counseling sessions, try to obtain specific information from Leon about his sessions at school with Gilbert? What if Gilbert does not want to disclose in the family sessions what he has discussed with Leon at school? Are there any circumstances under which it would be appropriate for Leon to terminate the counseling relationship with Gilbert at school and counsel him as part of the family system? Clearly, school counselors interested in opening a private practice must confront these potential ethical dilemmas and establish clear boundaries between their school counselor role and their private practice.

- If you are a school counselor, are you ever asked to take on non-counseling duties that could conflict with your counselor role?
- How do you handle such requests?
- What are the advantages and disadvantages of taking on extra roles and responsibilities?
- If you are a school counselor who also has a private practice, or if you are considering opening a practice, what boundaries do you need to establish to keep your two roles from coming into conflict?

Perhaps the best way to minimize dual relationship conflicts is for school counselors to clearly state their primary role and functions as counselors and to communicate this to teachers, parents, administrators, and, most important of all, to students. Demands made by principals, teachers, parents, and outside agencies can sometimes run counter to student clients' best interests. School counselors may feel as though they are placed in a no-win situation. If they object to taking on inappropriate duties such as monitoring restrooms or hallways, they risk being seen as uncooperative by administrators and as "privileged" by teachers. If they agree to take on such duties, they risk jeopardizing their counseling relationships with students. School counselors serve in multiple roles with multiple constituencies and need to have a repertoire of strategies for dealing with any conflicts that may arise. These include consulting with colleagues, clearly defining and publicizing their role and function, networking with others, and practicing personal stress management.

A Contributor's Perspective

Our next contributor, Catherine Geoghegan McDermott, draws on her experience as a school counselor to discuss boundaries with teachers, administrators, and parents.

Establishing Boundaries With Teachers, Administrators, and Parents

Catherine Geoghegan McDermott

The secondary school counselor has assumed an increasingly important position in schools. A school counselor can be an incredible asset to schools when given the autonomy to work as a mental health professional; however, school counselors often allow their boundaries to be eroded by administrators, teachers, parents, and even students as they are asked to take on duties that may be out of their realm of expertise or that may threaten relationships with students.

Before I continue, it is important to acknowledge that every school is a different system and every school counselor will have a somewhat different experience based on where he or she works and his or her relationship with the administrators, teachers, and parents at the school. My experience comes from working at an all-girls Catholic high school in a metropolitan area.

The relationship the school counselor has with his or her administrators is extremely important but may prove difficult to navigate. School counselors often work closely with the principal for a number of reasons, not the least of which is that school counselors have access to information about students, including their grades, behavior, and attendance records. Also, the principal is usually the one who will answer legal questions that arise at the school, and the school counselor may have sensitive information related to some of the issues. Finally, many (although certainly not all) principals do not clearly understand the role of the school counselor and may ask the counselor to perform role-inappropriate tasks such as disciplining students, moderating clubs or extracurricular activities, stuffing report cards and handing them out, or assuming cafeteria or carpool duty. I have often thought to myself—I didn't go to graduate school for *this*! Although it can be difficult for school counselors to advocate for their appropriate roles and duties, if they fail to do so, they will continue to perform these mundane and inappropriate duties.

When school counselors take on duties such as cafeteria monitor or club moderator, dual relationships with students are created that can both enhance and harm relationships with students. To illustrate, I offer the case of Maria, a high school counselor and the school's soccer coach. Maria is a caring and compassionate counselor, yet she is also a tough coach. During bus rides to games, she has been more relaxed than she typically is during the games, and she has chatted with team members about personal topics such as her taste in music and her past experiences as a high school athlete. Now, some of the students come and talk with her at lunch. They stop by her office, where they goof off and ask her personal questions, but also sometimes they share their struggles. Maria is aware that some of these students would not seek out a counselor if they did not know her as a coach, yet she also realizes that her personal

disclosures have led to more questions and that she has become uncomfortable and is uncertain about how to respond. Also, several other students on the soccer team who once sought her out for counseling now seem to be avoiding her. At this point, Maria may not be alone in her uncertainty—her soccer team members may be confused by differences between the supportive relationship they have with her inside her counseling office and her stern attitude as a coach.

School counselors also experience boundary issues in relationships with teachers. Teachers can be important assets to counselors because they see students daily and may refer students for counseling. However, they may ask follow-up questions that put the counselor in an awkward position. Take again the case of Maria, who is informed by a teacher that a student, Sophie, has been disruptive in class and that her grades have dropped precipitously. Because Sophie is on the soccer team, Maria is aware of difficulties Sophie is having at home, and she speaks with Sophie. When the teacher returns to Maria a few days later to report that Sophie's behavior and academic performance have improved, she asks, "So, what was wrong with her? Was it problems at home?" Maria will need to respond with sensitivity and tact so that she can maintain the good working relationship with this teacher.

Sometimes, teachers and school counselors may be friends, which can create a multiple relationship for the school counselor. Take, for example, the case of Angela, a school counselor who is close friends with a notoriously hard math teacher. One of Angela's students feels that the math teacher is treating her unfairly, but the student knows about Angela's relationship with the teacher. The student may not feel comfortable talking to Angela about her math teacher even though she needs an outlet to express her emotions and to find a way to cope with the difficult relationship.

Relationships with parents can be difficult to navigate at times. From a legal perspective, parents are the true clients in a counseling relationship with a minor. Ethically, however, the school counselor should protect the confidentiality of the student. An overbearing parent can be difficult to deal with when he or she learns that that a son or daughter has been confiding in the school counselor. Parents may call the school counselor to find out what is going on in the student's life, especially when the student's home life is problematic. Parents sometimes see the school counselor as an intermediary who can resolve parent–child relationships, but the school counselor must remember that he or she is not a family counselor.

One day, I had a parent call to let me know she had read her daughter's diary and found out her daughter was thinking about cutting herself. The mother asked me to speak with her daughter about cutting but without mentioning the diary or how I found out about her potential cutting. The mother felt that her relationship with her daughter would be ruined if the daughter learned she was reading the diary. This mother truly cared about her daughter but was asking me to have a conversation that would further

a pattern of lying and concealing that was already creating a wedge in the mother–daughter relationship. I spoke with the mother about having the conversation herself because I felt I could not conceal things from the student when our relationship was based on honesty.

Parents can be the most important assets for a school counselor in helping students, but the school counselor must work to establish a well-bounded, appropriate relationship based on informed consent. This can be accomplished in multiple ways: through written material, meetings with parents, meetings with students, and information in emails and on websites. School counselors must remember that informed consent with parents and students should be ongoing; it is important that the school counselor remind parents and students of why confidentiality is so important and of situations in which the school counselor will break confidentiality. When parents understand the nature of the school counselor–student relationship, they usually are happy to oblige the school counselor.

Boundary issues with the principal, students, teachers, and parents presented some of the most difficult challenges I encountered during my time as a school counselor. I found that I needed to be very aware of my own motivations in every relationship I had at school. Still, I made mistakes. I remember talking with a mom who was a veterinarian about my dog for 20 minutes before I realized I had hijacked the conversation. I wondered what I had communicated to the student, who was in the room. That she was less important than my dog? Although I never saw that real harm had been done, it was a lesson in vigilance regarding my boundaries.

Considerations in Crisis and Disaster Work

Unfortunately, today's school counselors must be prepared for large-scale crises. One of the newer roles for school counselors is to help coordinate and implement disaster response plans. It has become the role of the school counselor to work with administrators to develop a disaster plan and train faculty, staff, and students on how to implement the plan.

When disasters or crises occur, the school counselor must be aware of potential areas for boundary crossings. School disasters usually affect everyone in the school, not just students; therefore, school counselors must evaluate their emotional state to see if they are fit to counsel others. School counselors who do not take care of their own emotional needs by observing emotional boundaries during school disasters risk burnout. At the same time, it can be therapeutic for all involved when school counselors relax their boundaries to some extent during a crisis. In the example of a student suicide, it could be very appropriate for a school counselor to disclose that he or she is sharing in the grief and mourning process with other students. That disclosure may help to facilitate the grieving process in the school.

School counselors may be expected to take on different roles during a disaster. People may look to the school counselor for leadership in the

event of a disaster. Leadership is a quality that good school counselors have; however, they must be careful not to overstep their boundaries when making important decisions that should be reserved for administrators or board members.

Because events often move at a very fast pace in disasters, a good rule of thumb I try to follow is to slow down and consult with other professionals when I feel my boundaries being pushed. I have found that flexibility, self-knowledge, and consultation are the keys to remaining effective.

Social Media

The millennial generation has not known life without the Internet, cell phones, or social networking sites (SNSs). In the past 10 years technology has revolutionized how people connect with others via a Web-based format. Sites such as Facebook, Twitter, and Instagram enable people to share information about themselves in the form of posts, pictures, videos, and messages. Children and adolescents are quickly becoming the most frequent users of SNSs. Students find SNSs to be user friendly, convenient, and a great tool for communicating with peers and adults. Because SNSs form the basis for communication for our students, schools are quickly implementing programs to get connected to their students via online tools. Online communication is inevitable between school counselors and students. School counselors are already at a higher risk for dual relationships with students based on the nature of their work and the assigned tasks from their administration. Therefore, the concept of SNS relationships leads school counselors to one main question: To "friend" or not to friend current or past students?

A Contributor's Perspective

Our next contributor believes that today's students are digital natives with technology constantly in the palm of their hands. Kellie Giorgio Camelford identifies some boundary concerns regarding social media and friendships for the school counselor.

Social Media Site Friendships: A Slippery Slope for School Counselors

Kellie Giorgio Camelford

In the revised *Ethical Standards for School Counselors* (ASCA, 2010), a new standard was incorporated: "[School counselors] avoid dual relationships with students through communication mediums such as social networking sites" (A.4.c.). It is my observation that school counselors across the nation seem to have varying interpretations of what this statement means.

In my professional experience, I have seen two types of SNS dual relationship issues for school counselors: (a) school counselors accepting current or former students' personal SNS requests; and (b) school counselors creating professional SNS profiles, thus gaining access to students' personal information. I will illustrate how these diverse SNS relationships pose challenges for school counselors.

Personal SNS Relationships

I believe that school counselors should avoid personal SNS relationships with current or former students because this increases the risk for inappropriate relationships and can compromise confidentiality. A personal SNS profile is an individual's page that is not related to his or her job. School counselors who accept personal SNS relationships with students immediately convolute the counselor–student relationship because of the access gained by both the school counselor and the student to each other's personal information.

On Facebook, if a school counselor is "friends" with a current student, both have unlimited, uncensored access to view posts, pictures, likes/dislikes, friends' comments, and status updates. The school counselor could utilize this online friendship to learn about a student's thoughts, activities, and social life, which could help or hinder counseling sessions in school or create legal and ethical dilemmas. The student could perceive this online relationship as a friendship or see the school counselor in a different role, which may affect the counseling relationship. Consider the following scenario:

> Alaina Evans, a middle school counselor, is Facebook friends with Lindsay, one of her eighth-grade students. Lindsay comes to Ms. Evans for counseling because her father is an alcoholic. Ms. Evans went out one night with friends and had a few beers. A friend of Ms. Evans took pictures and posted the pictures on Facebook, tagging Ms. Evans in the pictures. Lindsay logged onto Facebook and saw the pictures of Ms. Evans. Without knowing Lindsay saw the pictures, Ms. Evans called Lindsay into her office for a check-in. Lindsay sat down and immediately stated, "I never want to talk to you again; you're just like my dad . . . a drunk." Ms. Evans was completely caught off guard by Lindsay's statement and did not know how to respond.

How would you respond as Ms. Evans? What perception does Lindsay have of Ms. Evans, based on limited information or photographs? Can this school counselor–student relationship be rebuilt? In this case, Ms. Evans's one night out with friends now has Lindsay questioning her character. This case demonstrates how quickly information travels on SNSs. It also illustrates that Ms. Evans could not control the information on her own profile page to prevent it being viewed by students because it was a friend that had tagged her in the picture.

In my experience, many school counselors refuse SNS relationships with current students but will accept personal SNS relationships with former students after they graduate. Because the school counselor–student relationship is officially terminated, what is the benefit for either the school counselor or the student in creating an Internet-based relationship? I think many school counselors do not fully "consider the potential for harm before entering into a relationship with former students or one of their family members" (ASCA, 2010, A.1.h.). For me, I see no benefit in becoming "friends" with former students; I see future boundary issues. In my opinion, school counselors who accept personal SNS relationships are weakening their counseling boundaries. Consider the following questions: What if previous students share your personal information with your current students? What if a former student sends you an SNS message that she wants counseling—would you counsel her online, tell her to drop by school, refer her, or not reply? What professional responsibility, if any, do you owe to former students and/or parents in a personal SNS relationship? For further reflection, review the following case:

> Carrie Greaney, a secondary school counselor, follows Emily, a recent graduate, on Twitter. Ms. Greaney had been Emily's school counselor for the past four years. They had developed a close counselor–student working relationship during Emily's sophomore year when her parents went through a divorce. Emily had had suicidal thoughts, and Ms. Greaney had worked with Emily's parents to see that Emily attended outside counseling. Emily would check in with Ms. Greaney on a regular basis throughout the remainder of her high school years. Six months after Emily's graduation, Ms. Greaney logs into Twitter on her iPad and sees the following tweet from Emily: "Good Bye World, enough is enough." Ms. Greaney panics as she reads the tweet and is not sure what to do with this information.

Through this scenario, one can see how personal SNS relationships can place school counselors in difficult ethical dilemmas where they have no control over a situation. Does Ms. Greaney have a duty to warn? What could happen if Ms. Greaney does or does not intervene? Does Ms. Greaney have a legal or ethical responsibility to this former student? Technically, the school counselor–student relationship is over because Emily has graduated. Yet ethically Ms. Greaney is concerned because she knows Emily has been suicidal in the past.

Professional SNS Relationships

It is an easy decision for me to not befriend current and former students on my personal SNS pages. My gray area lies in the feasibility of professional SNS relationships. Many schools have websites, blogs, and SNSs to promote the school and to communicate with students, parents, and the

community. These can be great tools to connect with students in a noninvasive way. There is a push by many school districts and administrators for counseling programs to have professional SNS pages, especially to communicate college, scholarship, part-time job, and general counseling information. This leaves school counselors with many questions and concerns. Some may interpret the ASCA standard as prohibiting all SNS relationships, and thus they do not have professional SNS pages. However, some school counselors believe it is important to have this type of professional SNS relationship as a way to advocate, guide, and communicate with students.

If school counselors do create professional SNS relationships, they will need to manage the relationships effectively to ensure that no harm is done to their students. Based on the ASCA ethical standards, school counselors should state the purpose of the site along with the rules and procedures for student usage. The intent of a professional SNS relationship is to convey personal, academic, and career information to students: however, based on how SNSs work, student information may be viewed by school counselors. Clear boundaries must be established through school policies, and informed consent needs to be obtained from both students and parents. School counselors should partner with parents to encourage Internet safety and responsibility. Students and parents must be aware of potential consequences such as confidentiality breaches of electronic information. New SNSs are being developed specifically for the academic arena, and these sites provide safeguards for both students and school counselors. Edmodo, which has features similar to Facebook, is used specifically for educators to connect and collaborate with their students. In this SNS, personal information is limited and the goal of the application is education. If such sites are managed appropriately, the dual relationship may have no negative impact on the counselor–student relationship.

Although professional SNSs give counselors a wonderful opportunity to communicate with students in a welcome format, they can be a doubled-edged sword for both the student and the school counselor. If policies are not in place, how should a school counselor proceed when confronted with a challenging scenario? For example:

> Mr. White, a high school counselor, uses Instagram, a photo sharing site, to upload pictures from the college trip to post on the counseling program's shared site. While on Instagram, Mr. White notices that Blake, a junior, recently uploaded pictures. As Mr. White is looking at Blake's pictures, he notices that there are alcohol and cigarettes in the pictures. Since Blake is underage, Mr. White is not sure what he should do, and his school has no policies regarding SNSs.

This simple scenario showcases the necessity for caution by school counselors when entering into professional SNS relationships because they

could lead to conflicting roles with the students they counsel. Is photographic evidence enough to bring the student in or to call his parents regarding his behaviors? Does the behavior need to be reported to the administration? What are the confidentiality considerations? The school counselor ethically aligns with the student regarding confidentiality; however, the counselor is legally responsible to the parents and the school. These scenarios illustrate many gray areas for school counselors regarding how information should be reported and who should be notified regarding SNS student issues.

Final Thoughts

Blurred boundaries may occur for school counselors in both personal and professional SNS relationships. Boundary issues include confidentiality, potential for Internet counseling, responsibility to students or parents, potential duty to warn, definition of the client, and consideration of ethical principles in counseling. The possibility of an inappropriate relationship or even an accusation of an inappropriate relationship could increase as well. The number of challenges regarding SNS relationships is overwhelming for the school counselor, but the demand for these relationships is driven by our students. It is vital for school counselors to create a delicate and appropriate balance regarding SNSs.

I am against befriending students at any point in time, believing there is no real benefit to either the school counselor or the student to stay in touch after the student leaves the school. However, I personally struggle with whether or not professional SNSs are appropriate. I constantly debate whether or not the benefits outweigh the potential risks. My biggest hesitation with professional SNS pages is that the school counselor may still have access to students' personal information, depending on the site. Would I be opening Pandora's box by having access to students' personal information? What legal and ethical issues would I need to consider if a student discusses harming him- or herself or others on such a site? What value am I providing by having a professional SNS—are there other outlets to create a similar effect?

I have struggled with professional SNSs for the past 3 years and have never created one because I believed the risks were too high. However, with new technologies and sites such as Edmodo, a safe space for social networking can be created for school counselors and students to connect. This new technology significantly decreases the potential risk for dual relationships or inappropriate behaviors.

School counselors must proceed with caution when exploring and implementing new media of communication with students via SNSs. School counselors have a professional responsibility to meet students on their developmental level and help guide them in personal, academic, and career choices. It is important for school counselors to be knowledgeable regard-

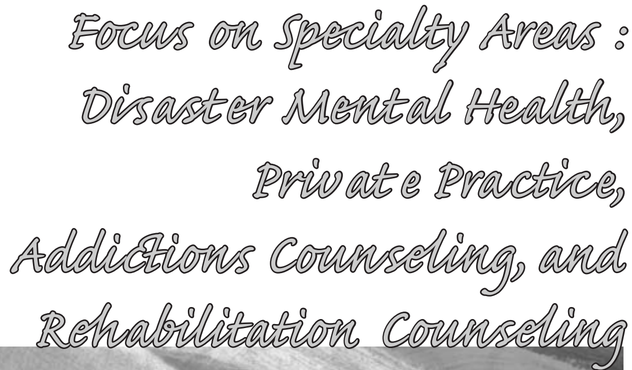
ing SNSs because this is the primary communication tool used by students. Personal SNS relationships with current and former students should be avoided by school counselors. If schools sponsor professional SNSs, school counselors must provide input on policy implementation, communication to students and parents, and classroom guidance lessons regarding SNS usage to protect the privacy of both students and school personnel.

Conclusions

School counselors often must balance multiple roles and are challenged to deal effectively and ethically with a range of boundary concerns. School counselors need to clearly articulate their primary role to teachers and other school staff members and avoid role conflicts that could compromise their central mission of counseling students. Some multiple roles of school counselors include acting as a consultant; dealing with suspected child abuse; and clarifying boundaries with teachers, administrators, and parents. When counselors are expected to act as disciplinarians, reporting student behaviors to parents or administrators or enforcing school policies at student events, students may lose trust in the counselor. In addition, the seemingly total involvement of today's students with social networking requires that school counselors think about the pitfalls as well as the possible benefits from use of these new media in school counseling.

Chapter 10

Focus on Specialty Areas: Disaster Mental Health, Private Practice, Addictions Counseling, and Rehabilitation Counseling



In this chapter we turn to issues pertaining to boundaries and multiple relationships that confront counseling practitioners in their work in the specialty areas of disaster mental health (DMH) and crisis work, private practice, addictions counseling, and rehabilitation counseling. We explore some of the unique boundary issues inherent in these specializations. The choices practitioners make on these issues are likely to either confound or clarify their attempts to practice aspirational ethics within an increasingly diverse world.

DMH

We begin our exploration of specialty areas with a focus on a growing specialization, DMH. An increasing number of mental health professionals are being trained by agencies such as the American Red Cross and the Substance Abuse and Mental Health Services Administration and are "on call" to respond to disasters as varied as the attacks of September 11, 2001, school shootings, fires, explosions, and natural disasters such as Hurricane Katrina that leave many people traumatized. DMH workers work under extraordinary conditions and face numerous challenges when ordinary boundaries do not exist. A DMH worker typically has no office or designated private space and is often called upon to perform in multiple roles.

A Contributor's Perspective

Our first contributor to this chapter, Gerard Lawson, draws on his experiences to present a picture of the complexity, and the challenges and rewards, of DMH work.

Boundaries in Disaster Mental Health

Gerard Lawson

In traditional counseling practice, consistent boundaries help clients identify and understand the professional nature of the therapeutic relationship, which may be different from relationships clients have experienced before. Effective boundaries also protect clients and the counselor, and the same is true in DMH counseling. Providing DMH counseling services involves unique challenges for skilled counselors, not the least of which is managing the boundaries between and among those involved. DMH counseling is not like a traditional therapeutic relationship. There are no scheduled appointments, services rarely take place in an office setting, there is no treatment plan in the traditional sense, and services are often acute and time limited. All of these factors contribute to a blurring of boundaries in DMH work that must be monitored to avoid becoming problematic. Boundaries are especially important and challenging in DMH counseling because of the intense nature of the relationship, the acute trauma involved, the volatile emotions, and the multiple demands placed on a DMH counselor.

DMH counselors can be called on to respond to large-scale traumas (e.g., hurricanes, earthquakes, acts of terror) and localized traumas (e.g., school shootings, automobile accidents, fires). In fact, the majority of DMH services for the American Red Cross are due to house fires, when families are displaced and family members may be injured or killed. Although hurricanes and terrorism make the headlines, the majority of DMH counselors are more likely to be involved with the smaller traumas that their clients encounter in their own community. I will discuss the boundary issues that are relevant for DMH counselors when clients experience a very recent traumatic event, are displaced and living in shelters, or are in a community in which infrastructure and activities of daily living are disrupted and when the counselor is personally affected by the trauma as well.

Recent Trauma

Most counselors believe that it is a privilege to accompany people on the journey through the most challenging times of their lives. That privilege is even more profound when sudden or traumatic events challenge the basic beliefs of the individuals who have been affected by the disaster. The intensity of DMH interactions, when a counselor is a stable and reliable source

of information and support, can result in relationships with very intense emotions. The counseling relationship in DMH needs to be managed respectfully and with sensitivity to the recent experiences the client has had. Counselors need to be sensitive to asking too many questions, driven by our need to gather pertinent information, which may feel intrusive and at times even retraumatizing, forcing individuals to relive something horrific. In fact, DMH counselors will occasionally be present when the survivor is receiving more bad news related to the event. Counselors may be present when the status is reported on damage to neighborhoods and homes, and specially trained counselors can occasionally be called on to participate in death notifications with the team of other professionals. Being present for these discussions creates a new dynamic in the relationship.

The intensity and nontraditional setting of DMH work can lead to issues regarding personal boundaries as well. A counselor is much more likely in a DMH setting to comfort clients with a hug or an arm around their shoulder as they are facing tremendous challenges. For many DMH counselors this is not a question of ethics or boundaries, it is simply the humane thing to do. Because DMH counseling is not a long-term relationship, a simple hug or other nonerotic touch might not seem inappropriate simply because there would be limited opportunity for a dual relationship to develop. However, the intensity of these relationships is such that counselors should still be very clear about identifying themselves as professionals in a helping role when it feels like the client needs a hug.

Recall that even if this particular relationship is not long term, most often counselors are providing DMH services in their own community. A client who has been through a difficult time and found support with a particular counselor may want to maintain that relationship. After one school shooting several years ago, professionals were used as family liaisons to work with the families of students who were injured or killed, and they served as a resource with school and community services that would be helpful to the family. Although their formal role only lasted for a few months, many families continued to call on these individuals for years after the shootings for information and resources and also just to share family news. That is testament to both the power of those relationships and how useful the DMH workers had been and also how the relationship can evolve without boundaries to help identify the parameters.

Sheltering

When there is a large-scale disruption of the community, oftentimes DMH services are provided in a shelter where families take temporary refuge. When working in these settings, boundaries are again challenged by the lack of private space and the fact that you may be having a therapeutic conversation on the cot that also serves as the client's bed at night. Survivors are dependent on disaster relief workers for the most basic needs

(e.g., food, shelter, clothing, medication, hygiene items) and for their mental health needs. DMH workers do not often draw distinct boundaries between providing counseling services and meeting some of the other basic needs of the survivor. Nevertheless, counselors should strive to create some sort of differentiation when they are moving in and out of the counseling role. That may be as simple as moving away from the living area of the shelter to a more private area with chairs, or being deliberate by verbally acknowledging when the counselor is moving in or out of the counseling role. Counselors must also be aware of their surroundings and sheltering situation to protect the privacy and confidentiality of the individuals with whom they may meet.

Community Disruptions

Even if sheltering and basic needs are intact, there continue to be challenges for the boundaries of the DMH counselor. In the days following a large-scale trauma, counselors will be stationed in areas where survivors will commonly gather. Following a shooting, this may be nearer the site of the impromptu memorials that are established. Following a natural disaster or an act of terrorism, predetermined locations are provided at a safe distance. These facilities occasionally serve as drop-in counseling centers, but when there are large gatherings of individuals, counselors will sometimes practice what we refer to as "compassionate loitering," which involves observing the crowd and reaching out deliberately to individuals who appear to be in distress. Even with the best of intentions, this is a counselor asserting the counseling role, without an informed consent or even an invitation, to someone who appears to need some support. The vast majority of times this is well received and can lead to an informal session in which the counselor is able to do a more thorough assessment and provide information or resources for the survivor.

Counselors also need to be aware that people can feel as if they are under the microscope when they are trying to attend a candlelight vigil or memorial service. Despite the fact that people are grieving, they are often also trying to live their lives. Seeing counselors in their workspace, where they eat lunch, or where they go for a walk to collect their thoughts may be welcome for some, but it may make others uncomfortable. Counselors need to be careful about balancing a passive presence that is compassionate and welcoming to someone seeking support and an assertive presence that some may find off-putting.

Working in a Team

DMH counselors almost always work as part of an interdisciplinary team to provide comprehensive services to those affected by traumas. Those teams may include individuals who provide for basic needs (e.g., shelter, clothing, water, and food), first responders, search and rescue, mortuary

services, and other social services and mental health professionals. When the American Red Cross trains their workers, they make it clear that the DMH worker is responsible not just for the survivors but for the mental well-being of everyone who is responding to the disaster. This can present some unique boundary challenges. Counselors will work side by side with other disaster relief workers in the field or in a shelter and then be called on to do a debriefing before those colleagues leave the site at the end of their deployment. The entire time that DMH counselors are working as part of the team, they are assessing how everyone around them (survivors and workers) is doing managing the trauma. In some ways that means that the DMH counselor must be part of and separate from the response team to be effective in the work: close enough to the group to be allowed to participate in frank discussions, and separate enough to be able to move seamlessly into a support role for a colleague. This raises one more interesting issue for counselors in terms of boundaries.

Simultaneous Traumatization

Whether disaster is a localized or national event, typically DMH workers are activated from the local region first and then, as greater resources are required, counselors may be called on from farther away. Oftentimes the first DMH counselors to respond are those who also have been most affected by the events. Before counselors from around the country were able to respond to the September 11 terrorist attacks, counselors in New York and New Jersey were on site. Before the Red Cross was able to mobilize counselors from across the country, counselors in the Gulf region were addressing the needs of those affected by Hurricane Katrina. There is some merit to this arrangement in that counselors from the local area know the resources and culture better than those from outside the community. There is also value in reinforcing the belief that “Our community is resilient and we are going to support one another.” However, this also puts counselors in the position of being both survivor and responder in their own community. Although we often caution counselors about vicarious traumatization and the strain caused by listening to stories of other individuals’ traumas, when it is in your own community, it is not vicarious. This is more akin to a simultaneous traumatization; each story you hear brings up your own personal recollections and reactions. In these instances, it is important for counselors to be aware of their own reactions to the trauma and to honestly gauge whether or not they can effectively assist others. Many of us want to contribute to the response and recovery when we see the pain and challenges around us. It is far better for counselors to honestly conclude that they were too affected personally and to choose to play a different role (or no role at all). The less attractive alternative is volunteering and creating a situation in which they may disadvantage another survivor because their own reactions are still too acute and unresolved.

DMH services can be very rewarding. The ability to help people when their world has been turned upside down is a unique opportunity, and people are drawn to it for a variety of reasons. But even counselors with the best of intentions, adequate training, and appropriate opportunities must be aware of the professional nature of their role if they want to be able to help the survivors with whom they will be working. Protecting that professional role requires appropriate boundaries so that survivors know how they can call on you for support and what that support will entail, so that team members can utilize the DMH counselor as a resource appropriately, and so that counselors themselves use good judgment and self-monitoring when determining when and how to serve.

Private Practice

For some therapists in private practice, circumstances can make it particularly difficult to maintain boundaries between their professional and personal or social lives. Private practitioners who work and live in small communities may find it impossible to avoid interacting with their clients outside the office. Counselors who share the same political affiliation, sexual orientation, or cultural background as their clients may also experience considerable overlap between the professional and nonprofessional aspects of their lives.

Private practitioners who use their personal residences for their offices may need to exercise particular care in keeping their personal and professional lives separate. Although having a private practice in one's home is not an ethical issue in itself, this practice does open up some potential issues. Both family members and clients need to be considered with this kind of office arrangement. It is not fair to children to banish them from the house, yet it is certainly not fair to clients to subject them to interruptions and household noises. If you do use a home office to see clients, you will need to design a private space for your work with them. Clients should not have to contend with interference during the therapy hour. Another consideration is that therapists, by using their home as an office, are revealing a good deal of information about themselves and their lifestyle. Finally, it is important to assess what clientele are appropriate and inappropriate for a home office practice. For example, clients who are potentially dangerous or who have serious problems recognizing and respecting boundaries should not be seen in such a setting.

A Contributor's Perspective

Harriet L. Glosoff raises additional boundary issues unique to private practitioners, who often face collegial isolation, overlapping community contact with clients, and the struggles inherent in being self-employed.

Multiple Relationship Issues in Private Practice

Harriet L. Glosoff

Most counselors, regardless of their work setting, will be faced at some time with the possibility of engaging in either multiple professional or a combination of professional and personal relationships with clients. Consider the following scenarios in which counselors may be faced with potential overlapping relationships:

> Marcus is a counselor in a small rural town. He coaches his daughter's soccer team and has become close to the girls and their parents. Yolanda, the mother of one of the girls on the team, asks Marcus if he would see her professionally. She has been struggling with depression for the past year and states that she is "struggling to get out of bed, let alone be a good mom." She considered going to someone else but the closest therapist other than Marcus is a 2-hour drive each way, and Yolanda cannot afford the time or money for gas to drive 4 hours each week.
>
> Lena is a counselor in a major metropolitan area. She has been active in an organization focused on equity for lesbian, gay, bisexual, queer, intersex, and questioning individuals and is well known in the community. Members of the organization have self-referred to Lena for counseling. Initially, most of the individuals who sought counseling with Lena were people she did not know well, and she accepted them as clients. Over the past few months, people who have served with Lena on committees and family members of some of the organization's members have also asked that Lena see them professionally. She has mixed feelings about doing so.

The counselors in these scenarios could be in any work setting. They would need to consider cultural issues and carefully weigh the potential for harm to clients against the potential therapeutic benefits.

Isolation

People often look to work settings as one place to meet people with whom they can form friendships or romantic relationships. In many ways, choosing to become a counselor, especially in a private practice setting, limits these opportunities. Because of this, private practitioners need to be even more aware than those in other settings to attend to nurturing their own need for personal connections.

One characteristic of most types of harmful multiple relationships with clients is that counselors put their needs above those of their clients, and their subsequent actions or inactions are detrimental to clients (Cottone, 2005; Kearns, 2011). This often involves clinicians looking for reciprocity in a relationship that is not, by its nature, fully reciprocal. Although the

relationships formed in counseling are intimate ones, this intimacy is one way, with counselors in the role of "givers" (Syme, 2003). Counselors must remain cognizant that a sense of mutual responsibility for needs cannot occur in the therapeutic relationship (Kearns, 2011); it is counselors who must attend to the needs of their clients. Brown (1994) sums this up beautifully when she refers to "the dance of relationships," noting that "therapy is always a pas de deux in which we [therapists] are the supporting partner" (p. 36). Counselors, therefore, must look to other personal and work connections to have their relationship needs met.

Private practice affords certain freedoms not found in many other settings: setting one's own hours; determining policies related to payment; and having greater choice over frequency, location, and length of sessions. Yet freedom and choices are accompanied by responsibility and problems not always encountered in more restricted settings. One such problem is that private practitioners often must grapple with their responsibilities and choices without a structure for support and feedback from other colleagues. This may contribute to feelings of isolation and an increased potential for emotional stress and burnout. When practitioners feel lonely, experience burnout, or are emotionally stressed, they also may be more likely to engage in behaviors that could be considered violations of appropriate therapist–client boundaries. These behaviors may range from seeking affirmation for being a good counselor to seeking a friendship or a sexual relationship.

Counselors need to have a clinical rationale for their actions with clients as well as their decisions when faced with any ethical dilemma, including whether to enter into blended or multiple roles with clients. A sense of loneliness or isolation may increase the chance of counselors basing their decisions on their own unique rationalizations instead of on clinical rationales. Counselors working from some theoretical approaches, such as traditional psychoanalysis, tend to conceptualize a need for strict boundaries in their relationships with clients. They believe there is a strong clinical need to avoid friendships with clients and see counselor self-disclosure as detrimental to the clinical process. Conversely, counselors who work from other theoretical bases, such as humanistic, feminist, existential, or behavioral bases, may view boundaries and self-disclosure in a different way. They tend to see self-disclosure as a way of strengthening therapeutic alliances and equalizing relationships.

Regardless of the theoretical orientation practitioners hold, it is critical that they recognize that their self-disclosures may be part of an unconscious agenda to have their own needs met rather than a way to empower clients (Kearns, 2011). Practitioners in independent private practice settings may fall prey to unintentionally using self-disclosures in sessions to counter feelings of isolation. Some clients may interpret such counselor self-disclosures as an invitation to develop a friendship or other nonprofessional relationship. Inappropriate self-disclosure may be especially

problematic if there are no colleagues with whom to "bounce off' ideas and share reactions to clients. Practitioners in other community settings tend to have more opportunity to receive feedback from their colleagues in both formal and informal ways.

Geographical, Cultural, and Professional Community Factors

Professionals who choose to enter private practice do not cease to be members of their communities. They do not become nonsocial, nonpolitical beings. For example, in addition to being a professional counselor, I have been trained in forms of holistic healing (e.g., certain forms of energy and breath work) that can be used as adjuncts to counseling. As was often customary in the healing communities in which I was trained, practitioners "swapped" or traded sessions as part of their own ongoing development, but no payment was involved. Early in my career, I was comfortable trading sessions with members of a peer breath work group. However, when members of my community asked to see me for counseling, I expressed concerns to them about doing this. Because clients often seek clinicians who share similar values or characteristics, it made sense to me that they would want to do "talk therapy" with someone they knew would understand their healing and spiritual practices. As a relatively new professional counselor, I also was flattered that they saw me as being able to help them. I was just starting my practice, and money was tight, making the idea of having paying clients tempting. However, I referred those individuals from my own healing community to other "talk therapists" for two reasons. First, accepting a fee for services changed the essence of our relationships, and I felt that this could ultimately negatively affect the energy and breath work practices that we did. Second, I had come to know a great deal about my colleagues through our training and posttraining sessions, and they about me. Especially as a new counselor, I did not trust that I would be able keep all of these issues in perspective.

It is unlikely that practitioners can totally avoid personal or nonprofessional contacts with their clients. This is especially true for those who live and work in certain cultural and political communities that are close knit. The political affiliations, sexual orientations, racial or ethnic backgrounds, or religious or spiritual beliefs of counselors may lead to counselors engaging in multiple roles with clients. Although this is true for counselors across work settings, those in private practice must remain vigilant against any temptation to use these factors as a way to solicit business. For example, counselors who serve on a political committee should not use the meetings as a forum for marketing their counseling services.

Counselors who live and work in small communities often find themselves in situations where they see clients outside their sessions. The same is often true for counselors who work for the military; are gay, lesbian,

bisexual, or transgender; are members of ethnic minority, feminist, deaf, or religious communities; or are recovering substance abusers (Syme, 2003). Clients may befriend partners or friends of counselors in these communities before knowing about their relationships, leading to an unintentional connection to a therapist's social life. This may be particularly problematic for counselors from such communities, whether they live and work in a small town or large city (Brown, 1994).

Although the focus of discussions on boundary issues should be on client welfare, it is also important to consider how engaging in multiple roles with clients may affect counselors. For example, regardless of the actual size of their town, counselors may wish to participate in community events and activities that bring them into contact with clients. This creates dilemmas for private practitioners, including how much they can be themselves and dance in the park at a concert or express unpopular beliefs at a political meeting. Does this mean that practitioners should not attend community events where clients may be present? Adhering to this as a hard-and-fast rule is overly cautious, in my opinion, and can lead to resentment on the part of the counselor. It is essential, however, for practitioners to discuss with their clients how seeing them outside the office affects them and how these encounters should be handled.

Financial Issues

Finances are another factor that can create ethical quandaries for private practitioners. Although any counseling that involves a fee inherently involves a form of multiple relationship, blending a business arrangement with therapy, in my experience this is often not adequately addressed in course work. This can leave counselors feeling unclear or anxious about how to deal with and talk with clients about finances (Kearns, 2011). Clinicians in private practice directly experience the financial impact of clients canceling their sessions or not showing up, insurers not reimbursing for services or limiting the number of sessions, and other fluctuations in income. Because of this, private practitioners may be more tempted to engage in behaviors that keep clients in therapy for longer than necessary. Over my years of participating in peer consultation groups with other therapists, this topic has been addressed many times. As difficult as it may be to admit, it is important to acknowledge that, especially during difficult economic times, therapists in private practice may either unconsciously or consciously increase clients' dependence or simply choose not to challenge clients when it might be therapeutically appropriate to do so for fear that clients may not come back and they will lose income. Further, private practitioners need to recognize that some clients may wish to stay in counseling because it provides a sense of intimacy or closeness that may be lacking in their lives (Moleski & Kiselica, 2005). It is essential for private practitioners to assess and monitor client progress, to adjust counseling

plans as needed, and to learn how to meet their need for income without seeing their clients primarily as objects that provide an income.

The *ACA Code of Ethics* (American Counseling Association [ACA], 2014) speaks to counselors advocating "at individual, group, institutional, and societal levels to address potential barriers and obstacles that inhibit access and/or the growth and development of clients" (Standard A.7.a.). Both pro bono and social justice advocacy work may entail serving individuals by providing direct counseling services but may also involve serving whole communities and the counseling profession. Just a few examples from my own experience and those of people I know personally include donating a few hours a week to counseling individuals at a local homeless shelter, conducting groups for children at a women's shelter, volunteering to provide career counseling at a community center in a city that was particularly hard hit by recession, providing training for free or at greatly reduced rates to an organization that helps people from poor economic communities move from city-owned housing to developing their own cooperative housing association, providing consultation services through community and government organizations in other countries, conducting professional development workshops for school personnel, offering to provide supervision to staff at community mental health centers in poor and rural communities, and volunteering to collect data for a private nonprofit agency so the organization could apply for grants. Again, these are just a few examples of ways in which counselors can engage in pro bono counseling and advocacy. Although private practitioners may build a certain amount of pro bono and advocacy work into their financial plan, the reality is that many will be unable to offer this on a regular basis or to offer free services to many clients.

In an attempt to maximize their availability and increase financial stability, counselors in private practice may find themselves using email and text messages to respond to client requests for information or in response to voice mail messages. On the surface this may not seem like a boundary issue, but it is important to consider how clients may interpret receiving communications from their counselors over the weekend or late at night. Sude (2013) cautions counselors about how the use of personal cell phones (rather than one specifically dedicated to the private practice) and the brevity and possible perceived informality of text messages that may lead to boundary confusion. Sude further raises important considerations about how time consuming communicating through text messaging can be. If counselors were to bill for their time spent sending text messages, as do other professionals, Sude wonders how they would determine the fee structure. If they do not bill clients for communicating via email or text messaging, might counselors become resentful? Might clients misinterpret such communication as casual or social? I would add that this as an issue of self-care, as I know many people who find themselves not realizing how many hours they spend in a given day on email and text messaging. I encourage counselors who do use email or text messaging in their practice

to establish policies ahead of time about billing and about ways in which they will and will not use electronic communication with clients. I also strongly recommend that they set specific times of day in which they communicate with clients on nonemergency issues and share this information with clients. This will help counselors manage their own time as well as avoid engaging with clients in extended "postsession" discussions.

A common conflict in private practice may arise when counselors accept clients for counseling services and later are offered the opportunity to be paid to evaluate these clients for court proceedings or, conversely, are asked to change from a forensic evaluative role to a therapeutic one. Similarly, clients may begin seeing counselors for individual work and then want to have the counselor see them for couples or family counseling. It may be tempting to change professional roles with clients when it is financially beneficial to do so, but boundary issues should be examined before accepting new and consecutive roles with clients. Counselors should be guided in such decisions by their theoretical rationale and the best interests of their client, and not by financial gain.

Some Suggestions for Private Practitioners

Given the intimate nature of counseling and the stressors involved with private practice, I am surprised that boundary violations do not happen more frequently. However, I wonder how many harmful multiple relationships exist that go unreported because clients are unaware of the harm or potential harm to them. How often have counselors hugged clients to appease their own need to nurture even though such behavior might interfere with clients' growth? Codes of ethics provide guidance in sorting out generally acceptable and unacceptable behaviors. They cannot, however, answer the question of whether it is appropriate to hug a specific client in a specific situation. More important than looking to codes of ethics for strict rules on boundary violations, counselors need to develop for themselves a core set of standards that guide their ethical decisions. I further believe that counselors should base their actions on theoretically sound principles. Although one might think that common sense can help us see the potential dangers involved with multiple relationships, as Alfred Adler once said, "If common sense were so common, everyone would have it" (as quoted in Gottlieb, 1994, p. 287). When we get caught up in our own issues, our common sense often leaves us. I offer the following suggestions as food for thought for counselors in private practice.

- *Recognize the complexity of therapeutic relationships.* First and foremost, I believe clinicians must recognize that overlapping relationships do exist. Refusing to acknowledge the power differentials in therapeutic relationships is similar to refusing to acknowledge that we have personal biases that come into our sessions with us. Denial does not make the potential problems disappear, and it precludes developing strategies to prevent them.

- *Attend to self-care.* It is important for counselors to take care of themselves. The codes of ethics of most professional organizations speak specifically to the responsibility of clinicians to engage in self-care activities. For example, the introduction to Section C of the *ACA Code of Ethics* (ACA, 2014) states that "counselors engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities." For many of us, providing pro bono and social justice advocacy work may feed the soul and our spiritual well-being. At the same time, it is important to be mindful that we need to make a living.

  Counselors in private practice can attend to emotional self-care by having friends and colleagues who are not clients and by finding ways to meet social and emotional needs other than those that involve a community shared with clients. Practitioners need to examine what possible harm can come to them, as well as their clients, if they enter into certain types of multiple relationships with clients. For example, as I previously mentioned, counselors may come to resent curtailing their own out-of-office behaviors so as to avoid engaging in multiple relationships. Counselors may resent watching out for their clients who are also friends, or they may actually end up minimizing their own personal needs to a degree that is unhealthy. This can lead to further erosion of appropriate boundaries with their clients, thus setting a dangerous cycle into motion. Seeking counseling for themselves to prevent or break such cycles is appropriate.
- *Engage in peer consultation.* Peer consultation can counter the feelings of isolation experienced by many private practitioners. I strongly recommend that private practitioners formalize some type of regular peer consultation rather than seeking assistance only in emergency situations or when faced with an ethical dilemma. I know that participating in peer consultation groups over the years has provided a safe place for me to examine my own reactions and actions, and I am sure it has helped me recognize and attend to issues of countertransference, my own reactions, needs, and motivations in my professional work and to boundary issues with my clients.
- *Engage in ongoing self-evaluation.* In addition to engaging in peer consultation, counselors can critique tapes of therapy sessions, with client permission, and keep a journal of their reactions, feelings, and concerns. These strategies can help counselors examine whether certain behaviors come up more frequently with some clients than with others and the extent to which interventions are well thought out.
- *Acknowledge the potential for multiple relationships and possible harm to clients.* Informed consent applies to helping clients understand that their therapists also live in a community. It is important to discuss with clients how meetings outside the office are to be handled along with the potential for the development of multiple relationships

and how this may harm clients. It is the therapist's responsibility to educate clients about therapeutic boundaries and how they can identify behaviors that are indicative of inappropriate boundaries. In addition, clients must be informed about avenues for recourse if they believe their therapist has engaged in improper behavior (e.g., reporting them to licensing boards and professional associations).

- *Use sound clinical judgment.* In examining potential for harm to clients, it is essential to examine not only the behavior in question (such as self-disclosure, serving on a committee with a client, or attending religious services in the same setting) but also the individual client(s) involved. For example, therapists will expect clients who exhibit features of a personality disorder to interpret counselor behaviors differently from clients who may not be able to manage these boundary issues. Counselors should remember that individuals who are basically healthy may also react in a variety of ways. A therapist's self-disclosure about his or her own experiences in dealing with anxiety may empower one client to think of anxiety in ways other than as a pathological condition. Other clients, however, may see this same disclosure as intrusive, a shift in focus away from the client's needs, a message minimizing the client's experience, or advice in disguise. Best clinical practices would indicate that clinicians have a responsibility to consider clients' state of mind, ego strength, and cultural factors before engaging in behaviors that may confuse clients about healthy therapeutic boundaries.
- *Remember the bottom line.* Regardless of theoretical orientation, personal philosophy, or financial situation, counselors are ethically responsible for meeting their clients' therapeutic needs, not the other way around. Clinicians do not have to give up attending social or community events simply because clients may be present. They are not required to ignore the realities of the business aspects of their practice. However, they must think through possible consequences of their behaviors and take responsibility for preventing harm (intentional or unintentional) to their clients.

Addictions Counseling

Substance abuse counselors who are themselves in recovery face some unique boundary issues in their therapeutic relationships with clients. Because the 12-step model is a significant part of addiction treatment in the United States, it is important to examine some of the most challenging boundary issues related to counselors working with addictions, which include dual relationships, ethics training, and ethical guidelines.

Dual relationships in addictions counseling can be complicated because of additional contact with clients outside the formal counseling environment. Encountering a client outside the formal counseling setting may

occur in a mutual help group, such as a 12-step Alcoholics Anonymous group. Counselors are often encouraged to attend both 12-step programs and alternative self-help groups to learn more about the groups to which they are referring their clients.

A Contributor's Perspective

In the following contribution, Laura J. Veach provides her thoughts on some boundary issues particularly relevant to addiction and substance abuse counseling.

Boundary Issues in Addiction and Substance Abuse Counseling

Laura J. Veach

I still find the familiar pull as I often see what addiction robs from caring people, from loved ones, and from families ravaged by the devastating downward progression of active addiction. Whether I see it in the various addiction faces of alcoholism, prescription drug addiction, or gambling, for example, the pain and life costs to health, work, and soul are wrenching. Recently, in my counseling work in a hospital trauma center, I met with a man struggling with an alcohol problem. His alcohol use had slowly increased over the past 25 years and recently reached such a level that severe injuries led to two recent admissions into the intensive care unit within 2 months. The amount of alcohol in his bloodstream on admission this time was 0.30%, a level that would likely result in coma in a casual drinker. His head and neck injuries were clearly alcohol related, and my counseling session with him verified the substantial health toll his heavy drinking was taking.

As a professional counselor striving to be fully present with him, I asked myself: How can I best help this human being who is aching to find a way to regain his health and his dignity? His story, like that of so many people grappling at the bottom of the cunning and baffling compulsive spiral of addiction, revealed a number of negative consequences. He was now unemployed, barely scraping by in his own home, had the electricity turned off in his home 2 years ago, had his driving privileges revoked, and had only a distant memory of his family. Once again I questioned all my ethical and professional training to determine how I could best be helpful to him. He was about to be discharged this day, and I knew I had a window of opportunity with this one counseling session.

Does it pull my heart? Indeed, the gifts of counselor empathy allow us to enhance our full presence with our clients, and I sensed both rugged tenacity and poignant loss in him and wanted to alleviate that pain. Because taking him home with me is not an appropriate answer in caring for those with addiction, I relied on the professional boundaries that have enabled

me to do this sensitive work for more than 30 years. Without these boundaries, I would have easily lost my way in spite of my positive intentions. Further, my own ability to assist my clients suffering with addiction would be decimated because of accelerated burnout. Imagine, literally or figuratively, bringing home your clients every day and how this would deplete you. Establishing appropriate professional boundaries enables us to work in an intensive setting, such as addiction treatment, for many productive years.

Some of the major challenges for substance abuse/addictions counselors involve boundary issues. The field of addiction and substance abuse counseling has changed in many ways during the past 10 years, with increased focus on brain research, new relapse-reducing medications, neurofeedback, inclusion of process (also known as behavioral) addictions such as workaholism (Chamberlain & Zhang, 2009) or sex addiction (Griffin-Shelley, 2009), emphasis on empirically supported practices, and new accreditation standards from the Council for Accreditation of Counseling and Related Educational Programs for addictions counselor education programs nationally (CACREP, 2009). A field once dominated by recovering counselors with a wide range of education and minimal formal training now has a growing prevalence of master's- and doctoral-level counselors specializing in addictions counseling. Credentialing has increased. In 2011, for the first time, more than 45,000 addictions counselors held international credentials through the International Certification & Reciprocity Consortium (2012). This represents a growing number of substance abuse/addictions counselor certification or licensure options worldwide, and rapid expansion is predicted in the United States with the passage of the Affordable Health Care Act (A. D. Kessler, 2010).

Thinking back to the client I described earlier, I recalled the challenges I faced. Using effective addictions counseling skills, I turned to him and explored intensive treatment options, which helped him to become aware of the consequences of his behavior with respect to his alcohol-related injuries and to his deteriorating health. He then chose to ask to be transferred to a residential setting specializing in addiction treatment for those with brain injuries. However, many other clients make different choices, electing instead to take home lists of counselor resources to perhaps use later. Whatever choices each client makes, I recognize my boundaries, mindful of transference and countertransference. How much of what was happening in the session was about his desire to change? How much was about my desire to rescue? Clinical supervision is of utmost importance along with addictions counseling skills to be optimally responsive to clients. This is quite different from believing I can or should take over to "fix" a person's life or hold myself responsible for the choices a client makes. As an effective counselor specializing in addictions counseling, I rely on well-defined professional boundaries and essential clinical supervision to guide me in the clear knowledge that I do not have all the answers for every client. It is essential that I recognize my limits.

Addictions counselors may encounter difficulty in obtaining the clinical supervision they need. Resources for clinical supervision tend to be inadequate, as was noted in a randomized clinical trial with addictions supervisors and counselors who received evidence-based skill training (Amodeo, Stortt, & Larson, 2010). The authors of this study concluded that supervisors are overburdened as "the addiction field is trying to disseminate evidence-based skills to a treatment system that is woefully deficient . . . and must find ways to identify low cost, quality training that counselors and supervisors can access" (p. 978). Insufficient clinical supervision resources are especially relevant given the challenging boundary issues often present in counseling individuals with substance use disorders. Many centers treating substance use disorders utilize evidence-based counseling approaches, which often involve seeing clients outside of the formal professional agency due to the encouragement of community 12-step support. With increased training and attention to evidence-based motivational interviewing (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; W. R. Miller & Rose, 2009), clients learn about 12-step support groups with this approach also.

Soon after I completed my master's degree in counseling, I accepted a position in a nonprofit agency treating substance abuse and addiction. Both recovering and nonrecovering counselors strongly urged me to attend open 12-step meetings, particularly AlAnon meetings, to learn more about healthy detachment, acceptance, boundary setting, and enabling. Over my 30 years of counseling in the addiction field with the Twelve-Step Facilitation model and other counseling approaches, I am grateful for such astute advice. I learned unique guidelines to address dual relationships and to minimize inherent problematic issues. For example, I learned to be more intentional in the beginning of the professional counseling process to prepare clients for seeing me at meetings. I clarified for them that I was not at any meetings in a professional capacity and therefore would not talk with them about professional counseling issues. This helped for the inevitable times I would see a client in a meeting when he or she might begin a conversation about something of a professional nature, such as a homework assignment. At these times I was able to gently remind the client of our earlier discussion, thus reducing an otherwise awkward moment. Counselors who are in recovery from addiction also face unique dual relationship challenges.

Professional Boundaries and 12-Step Meetings

It is strongly emphasized that counselors who may see current clients in a 12-step meeting keep in mind that "what is heard in meetings, stays in meetings." The 12-step fellowship cites the 12 traditions as important guidelines for its membership, and the eighth tradition clearly indicates there are professional boundaries: "Many of our members are professionals in their own right, but there is no room for professionalism in [Narcotics Anonymous]" (Narcotics Anonymous, 2008, p. 72). Recovering counselors

often are faced with deciding which "hat" they are wearing. Is a recovering person attending meetings for his or her own recovery or working as a professional addictions counselor? It is challenging to delineate between the role of a professional counselor and of a recovering person (Doukas & Cullen, 2010). It is important that counselors clearly communicate to clients that while they are in the 12-step meeting they cannot act in a professional role as counselor (Griffin-Shelley, 2009; G. A. Miller, 2010). Preferably, this clarification is established in the professional setting *before* a new client faces an awkward encounter with the recovering counselor at a 12-step meeting. This is especially important for those working with clients struggling with sexual and relationship addictions (Griffin-Shelley, 2009). The counselor can reiterate the main purpose for attending recovery meetings is for his or her own personal growth. Clear communication with informed consent, clarification about confidentiality guidelines, and caution help clarify this important boundary for the counselor and the client.

Another aspect of duality unique to the addictions field relates to counselor self-disclosure in 12-step or alternative meetings related to the counselor's own life experiences with addiction via personal recovery or that of a loved one. An overreliance on self-disclosure of one's recovery status may be used as a primary counseling tool yet not be therapeutic for the client. To best determine if self-disclosure is therapeutic for the recovering counselor, G. A. Miller (2010) recommends following these ethical guidelines: beneficence (disclosure is helpful to the client), nonmaleficence (disclosure is not harmful to the client), fidelity (disclosure fosters client trust), autonomy (disclosure helps the client with informed choice), and justice (disclosure is available to all clients in similar circumstances). Clinical supervision is an important tool for the counselor in discussing the delicate nature of self-disclosure as it pertains to addictions counseling, particularly if relapse occurs for the recovering counselor. Jones, Sells, and Rehfuss (2009) found a nearly 38% relapse rate in their small study of recovering counselors, resulting in recommendations for improved supervision policies to encourage earlier intervention.

Special Issues of Confidentiality

Facilities that provide counseling for addiction need to provide written guidelines in professional disclosure statements and in their informed consent documents that specifically address the assurance of confidentiality, anonymity, and a distinct separation of the recovering community from the treatment facility (Griffin-Shelley, 2009; G. A. Miller, 2010). For example, in some treatment settings, such as a halfway house where recovering addicts often reside after completion of an intensive phase of treatment, clients are expected by clinicians to be employed. Written guidelines need to be developed and clearly communicated to all employees working with clients when potentially exploitive hiring practices are a

possibility (Doukas & Cullen, 2010). Many clients with skills and abilities need to earn money while in early recovery and struggle to do so while experiencing repeated employment rejections. When a client has difficulty securing gainful employment, the addictions counselor may be tempted to hire the client on a temporary basis to help the client and benefit the professional with readily available labor for a home project, such as house painting. However, what seems like an innocent means of reaching out has the potential to harm the client. This could be the case if the job is not completed in a satisfactory manner and the counselor is then faced with increasingly negative feelings toward a client. Each agency needs clear and written guidelines discouraging temporary employment and other potentially exploitive practices related to hiring recovering clients (Doukas & Cullen, 2010).

Ongoing Supervision and Ethics Training

Ongoing ethics training and supervision are necessary to provide guidelines and direction for addictions counselors faced with dual relationships. It is the responsibility of supervisors and administrators involved in addictions counseling to continue developing policy and training for all addictions staff to provide quality care in the most ethical manner possible (Amodeo et al., 2010). Active supervision for counselors with professional experience ranging from a few months to many years utilizing live observation or taping sessions can alert the supervisor to potential boundary issues, and proactive steps can be taken to intervene and thereby reduce possible harm (Griffin-Shelley, 2009).

Addictions counselors with advanced degrees, but without knowledge of the recovery community, can benefit from ethics training with other addictions professionals who share what they have learned because of their personal understanding of the 12-step community. Credentialing requirements often include specific amounts of training in ethics for initial and renewing certification (International Certification & Reciprocity Consortium, 2012).

Summary

The needs of the substance abuse/addictions counselor involve specific considerations regarding dual relationships, especially related to mutual help group involvement. Improved understanding of the traditions and functions of 12-step groups can be extremely beneficial. Written agency guidelines, continued supervision, and ongoing ethics training are recommended to provide clear professional boundaries for the counselor working in substance abuse and addictions counseling settings. Indeed, these invaluable professional resources add to such meaningful work in addictions counseling.

Rehabilitation Counseling

Rehabilitation counselors facilitate the personal, social, and economic independence of persons with disabilities and, more specifically, help these people find or return to employment. Counselors are expected to take active measures to eliminate attitudinal barriers toward people with disabilities and strive to increase their own awareness and sensitivity to these individuals. They function in the role of advocate and work toward empowerment of clients by supporting their efforts at self-advocacy both on an individual and an organizational level (Commission on Rehabilitation Counselor Certification [CRCC], 2010).

Rehabilitation counselors face some difficult issues involving role conflicts and divided loyalties because they work in both the public and private sectors and serve multiple constituencies. Each of these constituencies has a vested interest in the outcome of counseling, and these interests are often competing and contradictory. For rehabilitation counselors—who may serve as counselor, gatekeeper to services, evaluator, and expert witness—the challenge is one of not simply managing dual roles but rather learning how to effectively carry out multiple roles. Because counselors have multiple obligations—to the client, to their employer, to the customer (the one who pays the bill), and to society—it is especially important that they be clear about their primary loyalties.

A Contributor's Perspective

Rehabilitation counselors play many roles, such as advocate, case manager, counselor, and forensic rehabilitation specialist. In the following contribution, Mark Stebnicki addresses the areas in which multiple relationships and role conflicts are likely to present ethical issues for rehabilitation counselors.

Managing Multiple Roles and Responsibilities in Rehabilitation Counseling

Mark Stebnicki

Rehabilitation counseling has a prolific history of facilitating person-centered and humanistic approaches for persons with medical/physical, cognitive, developmental, and psychiatric disabilities. The profession itself is a specialty area within the counseling profession. The profession has its own counseling accreditation standards (Council on Rehabilitation Education [CORE], 2012), counseling certification (i.e., certified rehabilitation counselor [CRC]) for practitioners (CRCC, 2012), and code of ethics (CRCC, 2010). CORE recently agreed to become an organizational affiliate of CACREP, which may add to the complexity of adhering to multiple standards. The hallmark of rehabilitation counseling is a counseling professional who works with the medical, psychosocial, and vocational as-

pects of persons with illness and disability. Because of the diversity of occupational settings in which rehabilitation counselors work, there is potential for multiple boundary issues that may occur based on the services and programs that are provided.

Roles and Conflicts for Rehabilitation Counselors

The scope of practice for rehabilitation counselors suggests that there is an ethical obligation and strong preference to act in a beneficent and nonmaleficent manner to facilitate empowerment strategies for persons with chronic illnesses and disabilities. The scope of practice also embraces the philosophy that rehabilitation counselors facilitate strategies that lead to helping clients achieve personally fulfilling, socially meaningful, and emotionally healthy levels of independent living, advocating for the client's autonomy. Multiple relationships occur when the counselor assumes two or more roles at the same time or sequentially with the client. The ethical principles of autonomy, beneficence, and nonmaleficence can sometimes give rise to ethical conflicts because, in practice, it is difficult to honor all three simultaneously. This is especially relevant for rehabilitation counselors where multiple relationships and boundary conflicts have potential to exist in the roles of (a) client advocate, (b) both case manager and counselor, and (c) forensic rehabilitation specialist or vocational evaluator hired by a rehabilitation health insurance organization. To gain a better perspective of the multiple relationships that challenge the rehabilitation counseling profession, I will first discuss some recent ethical issues identified by the CRCC Ethics Committee (CRCC, 2010). Then I will discuss the specific aforementioned roles and responsibilities of the rehabilitation counselor and some of the unique issues that lead to role blending and dual relationships, some of which may be a potential ethical concern for clients and counselors.

Concerns for the Profession

Indeed, the role and function of the rehabilitation counseling profession has exposure to multiple relationship issues that could potentially jeopardize the therapeutic boundaries between client and counselor. This is because rehabilitation counselors, depending upon state licensure laws, are qualified to practice across a variety of occupational settings and populations. Rehabilitation professionals are employed within community rehabilitation facilities, substance abuse and mental health programs, and vocational evaluation and career counseling–related services. In addition, some rehabilitation professionals are employed by private rehabilitation insurance companies or medical and vocational case management organizations in which "the client" may actually be an attorney or an insurance company. Accordingly, role blending appears to be a natural artifact of the profession itself.

A review of ethical complaints received as well as written opinions provided by the CRCC Ethics Committee between 1996 and 2012 suggests that managing boundaries and multiple relationships are common issues for the profession and relate to a broad range of rehabilitation practice settings (CRCC, 2010). Over time, the ethics committee has reviewed and cited multiple violations under Standard A.5: Roles and Relationships With Clients. Not surprisingly, this has historically been an ongoing area for ethics committee review as has been true for other professional counselor associations and their applicable codes of conduct (e.g., ACA, American Psychological Association).

More recently, the CRCC Ethics Committee has reviewed cases in which rehabilitation practitioners allegedly committed fraud by using the funds of the program or organization for personal use that has profited their own personal businesses (Section K.3.f.: Billing Records). Other ethical issues relate to forensic rehabilitation work when a vocational evaluator's documentation suggests that the evaluator was not providing objective or unbiased opinions regarding a client's disability during worker compensation or medical malpractice cases (Section G.2.a.: Misuse of Results). Some vocational evaluators who were not trained to diagnose and treat mental health conditions have crossed professional practice boundaries and have provided services outside their area of training and expertise (Section D.1.b.: New Specialty Areas of Practice; Section G.3.a.: Proper Diagnosis). Finally, in my review of the CRCC Ethics Committee minutes, I noted some cases in which personal relationships were formed with clients that extended beyond the limits of the therapeutic relationship (Section A.5.d.: Nonprofessional Interactions or Relationships). Overall, a review of CRCC Ethics Committee complaints suggests that multiple relationship issues and role blending do exist. They are common areas of concern for rehabilitation counseling practice.

Three Views From the Profession

Not surprisingly, the ethics committee issues just described are both the same as and different from those in other counseling specialty areas. I would like to highlight some distinct areas of role blending and other boundary issues that appear to be common within the rehabilitation counseling profession. Accordingly, the following discussion should assist in clarifying the professional roles, responsibilities, potential concerns, and solutions for rehabilitation counselors who act as (a) client advocate, (b) case manager/counselor, and (c) forensic rehabilitation specialist. I have personally worked across these particular roles and subspecialty areas for more than 25 years.

Client Advocate

As Maki and Tarvydas (2012) suggest in their comprehensive text *The Professional Practice of Rehabilitation Counseling*, the role of *client advocate* for the rehabilitation counseling profession has a historic mandate. First and

foremost, the role of rehabilitation counselor as client advocate makes for good professional and ethical practice. It is of paramount importance because people with mental and physical disabilities represent the largest minority and disadvantaged group in the United States. This is especially relevant for those who cannot speak for themselves or do not have a voice because of cognitive or communication deficits as well as for those who have psychiatric disabilities. In conjunction with other cultural traits (e.g., race, ethnicity, socioeconomic status), having a disability in America can lead to even more intense levels of social isolation, discrimination, stereotypes, poverty, and dependence on public/government assistance. In my experience working with clients who lacked the mental capacity to consent to any type of medical or mental health treatment, I had a natural tendency as the client advocate to become emotionally invested in the client's overall mental and physical well-being. This was especially true when the client had been manipulated by others or denied services or programs available to others, or when attitudinal barriers became more of a hindrance than the disability itself.

There are multiple relationship risks for rehabilitation counselors acting as client advocate, and we can sometimes justify our actions as being beneficent and nonmaleficent. We project the image that we always know what is best for our client. But at what point do boundaries become blurred when a personal relationship is developed with a child, adolescent, or adult client who cannot speak for him- or herself? Is the counselor acting more in the capacity of a "big brother or sister," or is the counselor working in a professional role, helping to protect client autonomy? Overall, the role as client advocate has potential concerns because of the intense emotional nature of the work when there is evidence of manipulation, wrongdoing, or human rights violations.

Acting as client advocate involves the integration of a variety of professional activities across a continuum of programs and services. The facilitation of empowerment strategies is key for ensuring client independence. In the role as client advocate, rehabilitation counselors engage in socially conscious and action-oriented behaviors. Some rehabilitation professionals may work to help remove institutional, attitudinal, and sociocultural barriers. Such barriers may hinder client participation in employment, education, housing, public transportation, as well as accessibility and independent living across multiple other life areas.

Professional counseling associations act in the role of advocates for their constituents (professional counselors), and rehabilitation counselors act as advocates for their clients. It is critical for rehabilitation counselors to understand how to engage their clients in the counseling process. Accordingly, it is paramount for rehabilitation counselors to facilitate self-advocacy or empowerment strategies to assist the client in cultivating higher levels of independence for the purpose of problem solving, healthy risk taking, and other therapeutic tasks. Overall, competent and ethical

rehabilitation counselors acting as client advocate know how to balance the multiple roles and responsibilities across a continuum of services offered to the client.

Some in the disability community, however, would argue that rehabilitation counselors acting as client advocate can foster dependency. Multiple relationships and boundary issues are a concern for rehabilitation counselors acting as client advocate, especially if they are not monitored carefully by the counselor or a qualified and competent clinical supervisor. The ethical principles of beneficence and nonmaleficence, if not carefully monitored, can indeed compromise client autonomy. Thus, blending the roles of consultant, adviser, or cultural facilitator combines traditional counseling and psychotherapy strategies with those of person-centered approaches to client advocacy. G. Corey, Corey, Corey, and Callanan (2015) provide a comprehensive discussion on blending such roles that can assist rehabilitation and other counseling professionals to ameliorate the consequences of acting purely in the role of client advocate. Many in the profession recognize the ethical complexity of these issues and that potentially beneficial therapeutic client–counselor relationships can exist if monitored, facilitated, and documented carefully.

Case Manager/Counselor

One of the more challenging roles for rehabilitation counselors is to blend the multiple roles and responsibilities associated with the rehabilitation counselor as case manager. Transitioning between these two separate job functions has potential for blending relationship boundaries, which sometimes may not be beneficial to the client.

The 2010 revised *Code of Professional Ethics for Rehabilitation Counselors* (Standard A.5.f: Roles and Relationships With Clients) provides some guidance for the professional identity or scope of practice dilemma. The revised code now allows members to serve in therapeutic relationships with clients as both counselors and case managers, as well as in other professional roles (depending upon training, education, and licensure) that transcend the traditional boundaries of professional rehabilitation practice. Standard A.5.f. has provisions that utilize professional disclosure statements along with client consent to straddle the boundary issues and role blending to ensure optimal therapeutic benefits and ethical behavior within the case manager–counselor role.

Forensic Rehabilitation Specialist

Forensic rehabilitation, as a subspecialty area of the rehabilitation counseling profession, facilitates the principles of vocational rehabilitation and primarily works within the disability-related legal system. This includes working with private attorneys who engage in medical malpractice and/or

catastrophic injury law, the state worker compensation system, and the Social Security Administration's Office of Disability Adjudication and Review, as well as providing vocational expert testimony in a variety of administrative hearings and court proceedings. I have also had extensive experience in forensic rehabilitation, for which the scope of practice includes such job tasks as occupational and transferable skill analysis, labor market surveys, life care planning (a comprehensive document that delineates the disability-related services that will be required to be given a catastrophically injured person over his or her lifetime), vocational evaluation, loss of earning capacity assessments, and vocational expert testimony. The primary issue that is at the heart of this subspecialty area is the long-standing ethical debate over who is the client in such cases: the insurance company, the claimant's attorney, the disability legal review system, or the claimant (the actual person injured).

One of the more important documents that can assist rehabilitation professionals with the role blending and multiple relationship issues within this specialty area is the professional statement of disclosure. A well-written disclosure statement outlines the intent and purpose of the client–professional relationship with guidelines and structure that describe appropriate case closure and termination of services. The disclosure statement should outline the rehabilitation professional's obligations to all parties involved.

Summary of Rehabilitation Counseling Issues and Empathy Fatigue

Whether rehabilitation practitioners work in the role(s) of client advocate, counselor, case manager, or forensic rehabilitationist, there are many programs and services that require blending multiple roles. Counseling professionals in general can be profoundly affected by the individuals, families, groups, and systems they serve, which may create empathy fatigue. This is a natural response to working with clients at intense levels of service.

I have done extensive work in this area, as seen in *Empathy Fatigue: Healing the Mind, Body, and Spirit of Professional Counselors* (Stebnicki, 2008) as well as my other research. I maintain that empathy fatigue results from a state of psychological, emotional, mental, physical, spiritual, and occupational exhaustion that occurs as counselors' own wounds are continually revisited by their clients' life stories of chronic illness, disability, trauma, grief, and loss. This ranges on a continuum of experience and leads to the deterioration of the counselor's resiliency or coping abilities.

Managing multiple roles and responsibilities within this context can hinder the counselor's ability to be therapeutically effective. Thus, a decline in one's ability to think, feel, act, and respond empathically with clients can itself create ethical problems in the area of counselor impairment, fatigue, and burnout. The point to highlight here is that counselors might

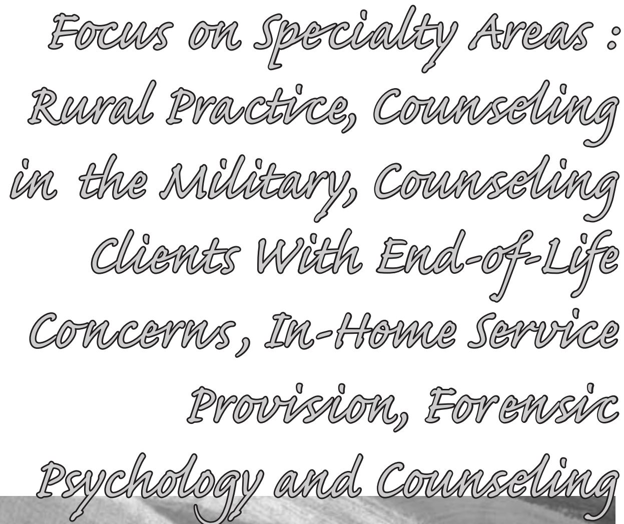
be open to the idea that engaging in too many roles and responsibilities has a mind, body, and spiritual cost. Cultivating self-care approaches regardless of your scope of practice requires constant attention and mindfulness to the fact that we are in a profession that serves those with the most intense needs.

Conclusions

This chapter has focused on four specialty areas—DMH, private practice, addictions counseling, and rehabilitation counseling—and has presented the perspectives of a practitioner in each area. Although these specializations are in many ways quite different from one another, they share a common thread in that they present some unique and complex boundary issues. The work can be demanding in each specialty area, and it is worth noting the emphasis that each guest contributor placed on the importance of counselor self-care.

Chapter 11

Focus on Specialty Areas: Rural Practice, Counseling in the Military, Counseling Clients With End-of-Life Concerns, In-Home Service Provision, Forensic Psychology and Counseling



In the specialty areas discussed in this chapter, you will see how the cultural context influences counselors' decisions about appropriate therapeutic boundaries. Nine guest contributors add their voices to this chapter: Holly Forester-Miller and Edward E. Moody Jr. discuss boundary issues that arise for rural practitioners. Brad Johnson draws on his experience to describe unique boundary questions that arise when counseling in the military. James L. Werth Jr. and Erica L. Whiting discuss boundary issues in working with clients who are terminally ill. Bonnie King raises boundary issues surrounding in-home provision of care, and Amanda Connell shares her thoughts on establishing boundaries when working with people with disabilities in their home. Finally, Robert Haynes and Stacy L. Thacker share some considerations for counselors who work in forensic settings. Our own experience with these specializations is limited, so we rely greatly on the expertise of our guest contributors.

Rural Practice

In rural communities, counselors may have to play several roles. In comparison to their colleagues who practice in urban or suburban areas,

they often find it more difficult to maintain clear boundaries and are frequently challenged in blending several professional and nonprofessional roles and functions.

Schank, Helbok, Haldeman, and Gallardo (2010) and Sleek (1994) point out that ethical dilemmas of managing boundaries are realities that are faced by therapists who live and practice in small communities. This reality affects the way therapists take care of themselves and how they balance the complexities of their personal and professional lives. In small communities, counselors often have to manage multiple relationships and blend several professional roles and functions. For example, a therapist who shops for a new tractor encounters a potential dual relationship issue if the only person in town who sells tractors happens to be a client. However, if the therapist were to buy a tractor elsewhere, this could cause strain in the relationship with the client because of the value rural communities place on loyalty to local merchants. In rural communities, clients may want to barter goods or services for counseling. Some communities operate substantially on a swap basis rather than a cash economy, and the potential for conflict in the therapeutic relationship arises if the bartering agreement does not work well.

Bradley, Werth, and Hastings (2012) identify three practical and ethical issues that mental health professionals who work in a rural setting must typically face. First, because many rural areas have few human service providers, the practitioner must often become a generalist in working with a wide array of problems presented by diverse client populations. Competence is a realistic concern when providers are expected to stretch their expertise in meeting the diverse needs of residents of rural communities. Second, learning to manage multiple relationships is especially important for rural practitioners. They need to function in a variety of community-oriented roles, such as a member of a religious group, a member on various boards, an educational consultant, and a sports coach. Rural practitioners often deal with the complications associated with being a professional and a person within a rural community. They generally live in the small community and are personally visible, and at the same time they must juggle multiple professional roles. Third, small communities are in many ways like fishbowls, which means that preserving the confidentiality of clients is fraught with difficulties.

Younggren and Gottlieb (2004) developed an ethical decision-making model for managing risk when contemplating entering into multiple relationships that can be applied to rural settings. Practitioners need to make a careful assessment of potential conflicts of interest, loss of objectivity, and potential consequences for the therapeutic relationship. Counselors are advised to discuss with the client any potential problems involved in a multiple relationship and attempt to involve the client as fully as possible in the process of making decisions. Informed consent is crucial, as is establishing clear boundaries. After this assessment and discussion, if the

multiple relationship seems appropriate, the counselor should document the entire process.

For a more in-depth discussion of concerns in small communities, strategies to minimize risk, and the challenge and hope of working in small communities, we recommend *Ethical Practice in Small Communities: Challenges and Rewards for Psychologists* (Schank & Skovholt, 2006).

A Contributor's Perspective

Holly Forester-Miller and Edward E. Moody Jr. explore how practicing in a rural community might make a difference in the appropriateness of dual relationships and how these relationships can best be managed.

Rural Communities: Can Dual Relationships Be Avoided?

Holly Forester-Miller and Edward E. Moody Jr.

If you were raised in an urban environment and have practiced exclusively in urban or suburban settings, the dual relationship issues experienced in rural communities may never even have occurred to you. Life in rural communities can be quite different from life in cities and can raise some complex issues for mental health providers. I (Holly) was raised on Long Island, New York, and then lived and worked in several rural communities in various states, so these differences have become all too evident to me. Initially, though, I was caught off guard.

Living in an urban area gives one a sense of anonymity that does not exist in rural communities. In rural areas, everyone lives and works in the community, and paths are bound to cross at some point. In a small town, the issue of counseling acquaintances is a moot point because nearly everyone is an acquaintance. Counselors need to distinguish among levels of acquaintanceship and friendship and set clear demarcations in deciding who will be appropriate to accept as clients. Our experience is that familiarity and trust are necessary ingredients to be an effective counselor in rural areas, and this observation has been echoed by other rural practitioners. Moleski and Kiselica (2005) point out, "The counselor who is about to begin a dual relationship is not always destined for disaster" (p. 7). They go on to say that refusing to provide counseling services to an acquaintance in a rural area might prevent that individual from receiving assistance, which certainly raises another dilemma.

Halverson and Brownlee (2010) interviewed Canadian social workers who worked in northern rural areas. The social workers noted that dual roles were unavoidable in their setting, and they were acutely aware of their need to manage these relationships. The participants indicated they would have liked to have received formal education and training in the navigation of these roles as well as clearer guidance from their professional

associations. The social workers interviewed believed that dual relationships could be beneficial when handled properly.

Pope and Keith-Spiegel (2008), in building upon Gutheil and Gabbard's (1993) conceptualization of boundary crossing, advise when making a decision to always ask, "What might be the best possible outcome?" They also recommend paying close attention to any uneasy feelings of doubt. We see these as good suggestions for making decisions regarding whom to see as a client when working in rural communities. Pope and Keith-Spiegel pointed out some errors helping professionals may make when crossing boundaries in rural practice. One common error particularly important to consider when working in rural areas is assuming that what happens outside of the counseling sessions has nothing to do with therapy.

Values and beliefs may vary significantly between urban dwellers and their rural counterparts. As counselors we need to work to ensure that we are not imposing values that come from a cultural perspective different from that of our clients. Just because someone may share your ethnicity and socioeconomic status does not mean that person shares the same cultural perspective and values. Working in rural communities we learned quickly that not all White, middle-class Americans have the same culture. For example, the values and beliefs related to marriage and the role of females in the family are often dramatically different in rural communities than they are in urban areas.

Bartering is a common practice in some regions and offers an opportunity for some individuals to receive counseling services. In the Appalachian culture, for example, it is a matter of pride to be able to provide for yourself and your loved ones. When I (Holly) practiced in Appalachia, I once counseled a suicidal teenage girl. I had discussed fees with her single-parent mother, who was insistent that she not receive free services. We set a significantly reduced fee. After a short time, it became apparent to me that even this small amount was a drain on the family's resources. So I broached the issue with the mother again and offered to see her daughter for free. This was not acceptable to her. She stated that she could make it on her own and take care of her family. She then asked if I might like her to make a quilt for me, instead of paying in money. Not wanting to get involved in the details and potential dilemmas of designing and planning a quilt with her, I asked her if she had one already made that she was willing to sell. She said that she did, brought in the quilt, and told me the amount she wanted for it. We arranged for that amount to be on account for her daughter's counseling. I had thought it through in advance and decided that I would accept the quilt no matter what the quality or whether or not I liked it or the colors. I did not want to put myself in a position to be judging or disapproving of this women's work. My sole purpose was to help the family, and especially to be able to continue to offer services to the daughter. In this case, bartering was the best solution because it allowed her daughter to receive needed counseling services and afforded

the mother an opportunity to maintain her sense of pride that she could pay her own way and provide for her family.

The *ACA Code of Ethics* (American Counseling Association [ACA], 2014) recognizes the realities of bartering as both a helpful payment method and a potentially exploitive arrangement.

> Counselors may barter only if the bartering does not result in exploitation or harm, if the client requests it, and if such arrangements are an accepted practice among professionals in the community. Counselors consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract. (Standard A.10.e.)

Both the American Psychological Association (APA) and the National Association of Social Workers (NASW) make provisions for the potential to barter, but with caution, and when it is an accepted practice in that community. APA's (2010) code of ethics indicates that a practitioner may barter as long as the agreement is not exploitive and is not contraindicated clinically. The NASW (2008) ethics code takes a more conservative stance, stating that bartering should be avoided and only utilized in "very limited circumstances" (1.13.b.). The social work code does recognize bartering as potentially needed, indicating social workers may participate in certain circumstances including if it is "considered to be essential for the provision of services" (1.13.b.).

Group counseling also poses some interesting dilemmas in rural communities. We typically assume group members do not know one another and have no outside relationships. This is an assumption that cannot be made in a rural community. For example, it would not be unusual for members of the same group to work at the only cafe, barbershop, bowling alley, or dentist office in town. Frequently clients learn about the groups they participate in from their church, mosque, or synagogue. Therefore, it would not be unusual in a rural setting to see someone in the group with whom they worship regularly. The group members are likely to know one another and to have preexisting relationships with one another. The members potentially having dual relationships with one another adds new dimensions to the process of trust building in the group.

Is it possible to avoid dual relationships in rural communities? We seriously doubt it. Counselors in rural communities need to be aware of the issues and challenges of dual relationships and be prepared to handle them appropriately to minimize the risks to their clients.

Counseling in the Military

Mental health professionals may provide services to military populations as either active duty commissioned military officers or civilian professionals stationed with military units—sometimes at very remote locations. In either case, counselors working with military service members find

themselves in daily multiple relationships with clients. Quite often these multiple roles are entirely unavoidable and are even a necessary ingredient in effective mental health care. At other times, these multiple relationships are uncomfortable or even distressing for client and counselor alike.

A Contributor's Perspective

W. Brad Johnson, a former Navy psychologist and now a colleague and consultant to many military mental health providers, highlights the reasons multiple relationships are an unavoidable ingredient in the daily lives of those working in the military and how military counselors can work to minimize harm to their clients in this environment.

Multiple Relationships in Military Mental Health Counseling

W. Brad Johnson

Multiple Roles in Embedded Military Environments

When a mental health professional is "embedded" or deployed with a military unit (e.g., an Army brigade, a Navy aircraft carrier, an Air Force squadron), that professional is typically a commissioned military officer who also happens to be a mental health counselor, social worker, psychologist, or psychiatrist. Here are some of the distinctive elements of mental health practice in embedded environments. Each of these factors clearly increases the risk of multiple relationships with clients.

- When a counselor is also a commissioned officer, he or she will have a legally binding senior–subordinate or subordinate–senior relationship with everyone in the population to whom he or she will provide mental health services. In this rank-conscious culture, it can be difficult to fulfill multiple roles such as empathic counselor *and* superior officer, or mental health expert *and* direct subordinate.
- Counselors in embedded or isolated duty stations cannot choose to enter or exit counseling relationships. Although civilian counselors might enjoy the luxury of being able to refer a client with whom they have or may have a problematic multiple relationship, military providers often cannot refer. Because the military counselor may be the only available provider in the deployed unit or at an isolated base, he or she must generally accept every referral and see every service member with a mental health need, regardless of whether the counselor is a close personal friend, a direct supervisor, or a coworker to that client. In fact, one should assume from the start that every member of the military unit is a potential client, including colleagues and close friends (Johnson, Ralph, & Johnson, 2005).

- At times, roles with clients might shift suddenly and with little opportunity to carefully inform clients. In embedded or isolated duty stations, a mental health professional might be directed to perform a fitness-for-duty or security clearance evaluation on a service member who is also a current, perhaps even a long-term, client. The sudden addition of a forensic or evaluative role with a client can cause confusion and distress. If the counselor determines that the service member is not fit for deployment or not a good risk for a security clearance, this outcome might naturally sour the counseling relationship if the client feels blindsided and betrayed.
- In contrast to civilian settings, counselors practicing in the military wield considerable power over military service members. The military is a traditional and hierarchical culture. In this context, commanding officers often defer to the judgment and expertise of mental health professionals when there are questions about a service member's mental health, fitness for continued service in the military, ability to deploy to a combat zone, and risk to self or others. These are high-stakes assessments with profound consequences for the service member's career. For this reason, counselors must remain sensitive to their degree of power over the lives and livelihood of clients.
- Finally, in military contexts, frequent and close personal contact with clients is nearly guaranteed. Deployed military units and small military bases are isolated and close-knit communities. Like counselors in rural communities, military counselors will find themselves in extra-counseling contact with most clients on a routine basis. When deployed with a unit, the counselor will find him- or herself eating, sleeping, and carrying out all the mundane tasks of life while (literally!) shoulder to shoulder with clients. For this reason, effective counselors need to develop a high comfort level with frequent boundary crossings.

Case Illustrations: Counseling on Board an Aircraft Carrier

To illustrate the daily boundary crossings and multiple roles mental health professionals might encounter when embedded with military units, consider life aboard an aircraft carrier. The following examples come from the personal experiences of two aircraft carrier psychologists, each stationed on a floating city of 5,000 military service members as the only mental health professional (Johnson et al., 2005).

- While sitting in my office a chaplain and a good friend of mine drops by. We make small talk for a minute, and then I see tears in the chaplain's eyes and realize this is more than a social call. I quickly try to adopt a professional counseling demeanor and spend a "session" trying to provide help. Later, I face the challenge of trying to resume

my normal social and professional relationship with this person around the ship.

- For several months, I have been counseling a dental technician. He is emotionally fragile and has made several suicide gestures. When I report to the dental clinic for my required teeth cleaning, he is delighted when he learns that he has been assigned to me. As he scrapes, sprays, and suctions, he unloads a stream of personal disclosures and free associations that would be much more appropriate for my private office. But I am a captive audience and try to listen empathically with my mouth full of equipment. After the session, I wonder if I should document this strange "session."
- I enter the ship's barbershop to get my hair cut. Behind the only open chair is a long-term client with a history of depressed mood and borderline personality traits. He has been suicidal and disruptive at work in the past. As I approach the chair, I try to recall whether he has ever expressed homicidal thoughts! He cuts my hair in silence and seems far more uncomfortable with this situation than I do.
- It is the busy dinner hour, and I am sitting at a table with friends enjoying a rare moment of relaxation during a day at sea. A young enlisted kitchen worker approaches the table and asks, "Are you the ship's psychologist?" When I answer in the affirmative, he launches into significant self-disclosure about psychiatric symptoms, relational problems, and trouble with his supervisor. Clearly uncomfortable, my friends are staring, trying not to laugh. As discretely as possible, I assure the young man that I would be happy to try and help and ask him to come by my office to make an appointment.
- One morning, my Social Security number was randomly selected for the Navy's drug screening program. When I reported to the medical department to provide my urine sample, there were only male observers, requiring them to radio for a qualified female observer. Over the speaker, I heard the name of one of my long-term clients respond that she would be right down. I realize that I cannot protest without revealing my relationship with this client. When she arrives, she gasps, "Oh no, it's you!" We both do our best to make small talk and maintain some professional demeanor as I disrobe and urinate in front of her. I wonder how best to "process" this strange event at our next counseling session.

These real-world experiences of deployed military mental health professionals reveal just how life on deployment or at a remote military base creates an environment that is rich in everyday boundary crossings. Of course, not all multiple role relationships are dangerous for clients or destructive to counseling relationships (Zur, 2007). In fact, there may be several clear benefits to being an embedded member of a military community. First, the embedded counselor will often gain a better appreciation for the

unit culture and the stressors common to members of the unit. Second, when the counselor is a visible member of the community, credibility will be enhanced, as the counselor is perceived as an "insider." Finally, service members in the unit will see embedded mental health professionals as more available and approachable.

Not all variations from traditional counselor–client boundaries are destined to harm clients or diminish the value of counseling (Zur & Lazarus, 2002). In the military, a counselor may find that flexibility in terms of meeting location, comfort with friendly interaction outside the counseling hour, and a willingness to model healthy behaviors (e.g., in the gym, at meals, in social contexts) pay significant dividends for clients.

Recommendations for Managing Multiple Relationships in the Military

Military mental health care can be fairly described as a multiple role environment. Counselors in these settings are advised to consider the following recommendations for managing multiple relationships and minimizing the probability that multiple roles with clients will cause unintended harm.

- *Assume that every member of the community is a potential client*. Without the ability to refer, counselors in isolated or deployed military units must stand ready to help any service member that walks through the clinic door. Recognizing this fact will help counselors to be selective when it comes to friends and confidants and thoughtful about their behavior in the community.
- *Provide detailed and ongoing informed consent*. Because boundary crossings are common and multiple roles unavoidable, it will behoove counselors to carefully inform new clients about the many extra-counseling interactions they are likely to have. Find mutually agreeable strategies for handling these interactions, and when some unanticipated boundary crossing occurs, be sure to discuss this with your client at the next opportunity.
- *Be conservative with self-disclosure and neutral on divisive issues within the community.* Keeping in mind that many members of the community may need the counselor at one point or another during deployment, avoid undue personal disclosures or entering the fray when controversy or conflict occurs within the community. Clients will feel more comfortable receiving mental health care from a counselor who is perceived to be professional and set apart from petty disagreements.
- *Consider alternative mental health resources.* Although you may be the only mental health professional assigned to your military unit, don't be afraid to find creative solutions should a potentially harmful multiple relationship arise with a client. For instance, if a counselor has recommended discharge from military service and the client is now

too embittered to continue a counseling relationship yet still requires care, it may be possible to find someone else in the community—such as a chaplain, a substance abuse counselor, or even a physician—to provide essential client care until a long-term solution can be found.

- *Establish and maintain an external consulting relationship.* Because a counselor in a military unit must be alert to the possibility of a professional relationship with anyone in the community, it is a good idea to have at least one solid collegial consulting relationship external to the military community. For example, a deployed counselor may benefit from an ongoing email or phone check-in with an external professional who can provide reassurance, perspective, consultation, and even friendship.
- *Increase tolerance for boundary crossings.* It is unsettling to eat, sleep, shower, and receive medical and dental care alongside clients unless a counselor can slowly increase his or her threshold for distress about routine boundary crossings. Without losing sensitivity to boundary violations or multiple roles that make a client distressed, an effective counselor to military service members will need to see the humor, irony, and unavoidability of day-to-day crossings of traditional counseling boundaries.

Concluding Comments

Like counselors in cloistered religious settings or rural communities, those practicing in military contexts must become comfortable with boundary crossings and multiple roles with clients. In my own work as a military psychologist, I have tried to find the middle ground between phobic avoidance of contact with clients outside the counseling hour and laissez-faire insensitivity to the ways that this contact might affect my clients. Moreover, in thinking about multiple roles, I try to imagine how to integrate the best interests of an individual service member with the best interests of the military mission. For instance, a friend of mine who happened to be a neighbor, a frequent running partner, and a Navy pilot informed me during the course of a run that his new job responsibilities were causing him serious distress. Specifically, he was quite anxious and suffering insomnia. Although I encouraged him to seek mental health services through the Navy medical clinic, I knew very well that he would not. Pilots typically avoid mental health care at all costs for fear of losing their flight status. After some consideration of this dilemma and some consultation with a colleague, I decided to embark on a trial of "therapeutic runs" with my friend. By this I mean that during our twice-weekly runs, I began to discuss sleep hygiene and cognitive strategies for lessening anxiety. I never provided formal informed consent, I never created a client chart, and I never made a professional note in my friend's Navy medical record. In the end, my friend's symptoms became

more manageable and eventually resolved and the Navy retained an excellent pilot and an expensive asset. Although different circumstances (e.g., more serious symptoms, concern about impairment on the job) might have guided me in a different direction, I hope that my willingness to cross a boundary and have more than one role with my friend resulted in a positive outcome for both him and the Navy.

Counseling Clients With End-of-Life Concerns

There are no simple answers to questions pertaining to end-of-life concerns, but counselors can assist their clients in making decisions within the framework of clients' own beliefs and value systems. Counselors must also address both ethical and legal issues regarding end-of-life care and be prepared for work with family members. It can be a struggle to balance the need to protect client rights to autonomy and self-determination with the need to meet the counselor's legal responsibilities. Counselors who work with individuals concerned about end-of-life care must know the laws in the jurisdiction and state where they practice.

A Contributor's Perspective

James L. Werth Jr. and Erica L. Whiting highlight a few of the boundary or multiple relationship situations that may arise when working with dying clients. As is the case with many ethical dilemmas, it is best to try to anticipate possible issues that may arise and get informed consent when possible. Consulting with a knowledgeable colleague or turning to the literature will help counselors recognize some of the common dilemmas early in the process and develop a plan.

Boundary Issues and Multiple Relationships When Working With Clients With End-of-Life Concerns

James L. Werth Jr. and Erica L. Whiting

As the authors and contributors to this book have emphasized, the primary issues and concerns associated with multiple relationships are not the facts that boundaries may need to be flexible in some cases or that counselors may have different roles with clients but rather the possibility of exploitation of the client, conflict of interest for the counselor, or impairment of the counselor's abilities. Absent these issues, multiple relationships are not necessarily unethical or illegal, but counselors need to look at their state's standards of practice in their licensure regulations because at times these can be more restrictive than professional ethics codes.

Gamino and Bevins (2013) identify a host of ethical challenges and dilemmas counselors may need to consider when they work with clients facing decisions about end-of-life care: respecting client autonomy, assessing an individual's capacity for decision making, honoring advance directives, respecting an individual's cultural values, maintaining confidentiality, dealing with medical futility, establishing and maintaining appropriate boundaries, and including families in the scope of care.

Here we focus on boundary issues pertaining to end-of-life care. We like the decision-making model by Herlihy and Corey that is presented in the last chapter of this book. According to that model, once a counselor decides to enter into a set of multiple relationships or cross a boundary because the benefits outweigh the risks, the counselor should do the following:

- Discuss the situation with the client in order to obtain written informed consent.
- Seek consultation at the outset and then periodically throughout the time the multiple relationships are occurring.
- Continue to discuss the situation with the client to minimize problems.
- Thoroughly document the decision to engage in the multiple relationships and then document decision points along the way as well as the client's reactions.
- Monitor his or her own reactions to developments and discuss them with a consultant.

These general guidelines can be applied when working with a client who is dying when the significant needs of the client and his or her family may call for regular and ongoing decisions related to boundaries, roles, and relationships. We appreciate the opportunity to offer our perspectives on issues that counselors may want to consider when providing services for dying individuals and their loved ones. To highlight the topics we are discussing, we refer to a case based on real clients but that has details changed to protect the identity of those involved. Throughout the presentation of the case, we focus on the boundary issues, thereby minimizing many of the other complexities that exist in a case such as this. We leave the resolution of each issue to the reader but offer a series of questions or points to consider.

Location of Service Provision

When working with clients who are dying and their loved ones, some of the standard assumptions about how counseling works or the typical client–counselor arrangements are no longer applicable. For example, counselors often see clients in their offices with the door closed and no one else in the room. Depending on how close to dying they are, many clients dealing with end-of-life issues are unable to get out of their bed at home or

a facility (e.g., nursing home, hospital, inpatient hospice). Thus the counselor will need to travel to the client's space, which may not be private and may not have a place for the counselor to sit down or sit anywhere other than on the bed. Further, the client may not be able to communicate verbally because of tubes, lack of breath, or other medical conditions, and the sessions may need to be short because the client lacks the energy to talk very long or is on medication that affects cognitive functioning. To illustrate these points, consider the following scenario involving a counselor, Jane, who has been seeing Don, a client who has cancer.

> When Jane saw that Don was not in the waiting room, she became concerned and called his number. Shirley, Don's wife, answered and was clearly flustered when she realized they had missed Don's appointment. She said that Don was weaker and she was not able to get him out, so she asked Jane to come over to their house. She said that "Don and I really need your help."

- Jane needs to decide whether to go to Don's home. We hope she has considered that this might be an issue and will have a response ready.

> Hearing the strain in Shirley's voice, Jane agreed to drive to their house after her counseling day was over. Upon Jane's arrival, Shirley took Jane to the bedroom, where Jane saw that Don had visibly declined. Jane tried talking to him about how he was doing, but he faded in and out of consciousness. Shirley and Jane discussed Don's cognitive difficulties, and, as Jane was leaving, Shirley requested that Jane come earlier in the day when Don was more alert. Shirley also said that it would help if Jane would not wait another week to return.

- At this point, Jane has to decide whether to continue the counseling relationship at all, attempt to continue it in person by going to Don's home, or perhaps attempt to continue it using technology.
- If Jane does decide to continue, she will need to consider how often and at what time of day to schedule time with Don. If she goes during the day, she will have to consider that between the drive over and back and talking with Shirley, she would not be able to see anyone else for several hours—a potentially significant loss of income.
- If Jane decides to end treatment, she should think about the potential consequences of abruptly ending services and consider alternative options for Don's continued care (e.g., identifying referral options).

Providing Practical Support

Another issue that may arise that normally would be viewed as outside the bounds of good practice is providing practical support for the client.

For example, it would be unusual to provide physical assistance to a typical client seen in outpatient counseling, but a dying client may need help getting into the counseling room, may need to be helped to the bathroom or even while in the bathroom, and may need to lie down during or after a session. If the counselor is going to the client's own space, there may be even more atypical situations, including requests for assistance with cleaning the area, preparing meals, or even picking up supplies on the way over to the client's location. We now revisit the case with Jane.

> At the beginning of a session at Don and Shirley's house, Shirley said they were running low on several things and asked Jane if it would be okay if, while Jane was there, she could go to the store to buy some essentials to get them through to the next day until their son arrived. Jane felt uncomfortable and did not know what to do. She was nervous because she was unsure what she would do if Don seemed to take a turn for the worse while she was there with him alone.

- In this instance, not only must Jane consider her initial reactions of discomfort and concern about being left alone with her ailing client, but she must also take into account the wife's demanding caregiver role as well as how her response could affect the client and the therapeutic relationship.
- If Jane says no, there is a possibility of creating an additional burden and distress for Shirley, who must find a different time to get supplies and someone to care for her husband while she is away.
- If Jane says yes, she may open herself up to risk if an emergent situation arises, such as respiratory distress, failing organs, or even death.
- Other non-life-threatening but still challenging issues may arise while Jane is alone with Don. What should Jane do if Don wakes up and says he needs help getting to the bathroom? It is possible that he may be so weak that she may have to almost carry him to the bathroom, sit him down on the commode, help him up afterward, and virtually carry him back to bed.

> Days later, Jane was scheduled to meet with Don at his home. She called the morning of the appointment, and Shirley said she was glad Jane was coming over because she needed to go out again to get some medical supplies.

- At this point, Jane has a decision to make. Remembering her discomfort the last time, should she offer to pick the items up on her way over and get the list from Shirley? Or should she tell Shirley that she does not want to be left alone again?
- If Jane does get the supplies en route and deliver them to Shirley, should she give the receipt to Shirley and ask for reimbursement?

Assisting the Loved Ones of the Client

In addition to providing therapeutic and practical support for the client, there can be a tremendous pull to provide some assistance or support to the loved ones of the dying person even if the counselor is officially providing (and billing for) individual counseling. There is a large literature on the needs of caregivers (see, for example, Waldrop & Kirkendall, 2013). Any counselor who interacts with the loved ones of someone who is dying will likely see the effects on these other individuals. The counselor may want to help them, either out of altruism or because they catch the counselor before or after the session with the dying person. Being prepared for social interactions that are atypical in most counseling settings is helpful. For example, a counselor may be invited to stay for coffee after a session that takes place in the client's space. Bereavement can affect health and even longevity, and some people may have complicated grief issues. Counselors need to determine how to assist loved ones before death occurs while not negatively affecting their relationship with the client (Neimeyer & Burke, 2013). Now let's return to the case of Jane and Don.

When Jane went to the kitchen to tell Shirley that Don was sleeping and she was going to leave, Jane saw that Shirley had been busy preparing a big lunch. Shirley asked Jane to stay so they could eat together.

- If Jane says no, what will that do to the relationship with Shirley and, by extension, Don?
- What should Jane share with Shirley (assuming a release has been signed)?
- What if Shirley becomes tearful and then angry as she talks about how hard the last week has been and how little support she feels she has had?
- What if Shirley also mentions how lonely she has been because people do not want to come over anymore and she has been unable to get to church now that Don is bed-bound?

In a later session, Don talks to Jane about his funeral.

Don says he wants Jane to help Shirley after he dies and to be with her at the funeral. Don also asks Jane to tell his children that he loved them and that he was sorry he had not been a better father.

- Would Jane's presence at the funeral violate confidentiality? How should she manage interactions with other attendees?
- If Jane continues to help Shirley after Don's death, will Shirley become a client or will Jane be providing this service for free?
- Would it be therapeutic to encourage Don to make amends with his children in his final days instead of relaying the message to the children herself? Should Jane facilitate a family session?

Cultural Considerations

Cultural considerations will not only affect the dying process, and the decisions dying persons and their loved ones make before and after death, but also affect the relationship counselors have with people who are near the end of life and their significant others (Kwak & Collet, 2013). Cultural beliefs influence rituals that may be carried out, who makes decisions, and what it is acceptable to verbalize. Although it is not possible to be fully informed about every cultural group, counselors should engage in discussions about the beliefs of the dying person and loved ones early in the process to be prepared for times when culture intersects with the counseling process. For example, although considered important by the majority culture, a living will (which allows a person to state what medical interventions she or he wants or does not want done if unable to speak for her- or himself) may be unacceptable to a person whose culture subscribes to the belief that to plan for death may cause it to occur.

In this excerpt, Jane speaks with Don and Shirley about options for care and Don's preferences for treatment when he is no longer able to make medical decisions.

> Jane asks if Shirley had thought about hospice, at which point Shirley becomes upset and says that they are not going to give up. She says that she had been praying and that God will help them. Even when Jane notes that research shows that people in hospice live longer, Shirley repeats that they are going to keep trying everything possible. Jane decides to move on and asks whether Don has completed a living will or designated a power of attorney, which would allow someone to talk for him if he was unable to speak for himself. Again Shirley says that these are not necessary because Don is going to get better.
>
> In a subsequent session with Don, Jane again mentions the possibility of hospice. While looking at Shirley, he repeats the same thing she had said about not giving up. Jane therefore switches to the living will and power of attorney forms and explains that these would allow him to have his wishes followed if something unexpected happened while also taking some of the pressure off Shirley. He agrees to do the living will form, and they complete it together, with Shirley's input, saying that any and all interventions should be tried. Jane explains that the power of attorney form would help cover situations that came up that were so unexpected that they were not covered by the living will form. This form allows the person who is named on the form to talk to medical providers and make decisions about the care and treatment of the ill person. After a period of silence, Don says that he thinks this form is important but that Shirley is not good at talking to people at the hospital, so he wants Jane to be named as his power of attorney. Jane looks at Shirley, whose head is down, and sees tears are spotting Shirley's slacks. Shirley looks up at Jane and nods her head.

- Jane should reflect on her own beliefs regarding prolonging life or ending suffering and consider disclosing and discussing these views with Don and Shirley.
- Jane may also need to take into account some practical aspects of making medical decisions. How much time should she spend at Don's bedside or consulting with physicians to make an informed medical decision? Can she spend this much time away from her practice and personal life or go to the hospital at a moment's notice?
- In addition to thinking about her own reactions to becoming Don's power of attorney and what this means if she must actually act on his behalf, Jane needs to consider the potential impact on Don, Shirley, and other family members if she says yes or no.
- Jane also needs to consider what may happen if she has to make a decision that may affect the manner and timing of Don's death, especially if family members may disagree with her decision.

Concluding Comments

The situations and dilemmas highlighted in this case are fairly common when working with clients near the end of their lives. These are but a handful of the boundary and multiple relationship issues that need to be considered by counselors working with dying clients. We have not touched on other complicated ethical dilemmas, the impact of developmental considerations, the influence of mental health conditions, or the possibility of cognitive impairment (see Werth, 2013a, 2013b). All of these layers will affect how the counselor works with clients and their loved ones and manages boundary considerations. By anticipating potential issues, counselors can develop a plan in advance and mentally prepare themselves for the situations they may encounter.

Our discussion in this contributed piece is necessarily brief. For those interested in more information about ethical issues related to end-of-life care, we recommend these resources: Standard B.2.b. in the *ACA Code of Ethics* (ACA, 2014) on "Confidentiality Regarding End-of-Life Decisions," "End-of-Life Care: An Overview for Professional Counselors" (Werth & Crow, 2009), and *Counseling Clients Near the End of Life: A Practical Guide for Mental Health Professionals* (Werth, 2013a).

In-Home Service Provision

The traditional approach to counseling that takes place in an office for a 50-minute hour may not be a good fit for many people. Knapp and Slattery (2004) point out that home-based services may be the only way some people can access services because of transportation problems, mobility issues, or cultural barriers to office-based treatment. Counselors who go outside the office to deliver services in the community may need to acquire a unique perspective and a different set of interventions.

Home-based therapy has been used extensively with ethnic minority clients and families because many people in the community do not trust traditional mental health professionals (Zur, 2008). Zur comments that making a home visit with these clients can be a way to get a firsthand view of their home, rituals, neighborhood, community, and support system. Going outside the office can decrease suspicion and enhance trust. Providing home-based services can also lead to ethical challenges in managing professional boundaries. When working in the homes of clients, Knapp and Slattery (2004) recommend that therapists emphasize informed consent, especially with regard to therapeutic boundaries. They also recommend, as much as possible, considering the potential impact of boundary crossings on the therapeutic relationship before they occur. When counseling takes place in a client's own home, a new set of challenges for maintaining boundaries must be addressed.

A Contributor's Perspective

Bonnie King describes some unique boundary issues that arise when counselors provide in-home services to children and teens with severe behavioral and mental health concerns.

Boundary Issues Pertaining to In-Home Service Provision

Bonnie King

As a mental health rehabilitation counselor in New Orleans, Louisiana, I have found that boundary crossings can occur frequently and can be difficult to navigate at times. I work for an agency that provides services to children and teens with severe behavioral and mental health concerns. They are referred to our agency through schools, parents, teachers, and social workers. The children and adolescents I see are incredibly diverse in age, ethnicity, personality, and presenting reasons for participating in therapy. Because of the intimate nature of the work in homes and the sheer amount of time I spend in the home, at times boundaries can become blurred and can create ethical issues. Some that come to mind are confidentiality, defining the client, the various roles of mental health professionals in this environment, fidelity to the company versus fidelity to clients, and personal boundaries of the counselor.

Confidentiality

This case study illustrates some of the dilemmas that may arise with respect to confidentiality when counseling takes place in the home:

> Daveon, a seventh-grade boy with severe mental illness, was assigned to be my client. He was unmedicated and sporadically showed up to doctors' appointments only to choose not to fill his prescriptions later. His mother was

also suffering from mental illness and was limited in her ability to care for her child. Daveon refused to speak to me except in the form of obscenities. Usually he simply said nothing or aggressively sang violent rap music in the other corner of the room. I continued to "show up" and to try every trick in the book, and one day he picked up the paints that had been left on the table and started to paint. This began a tentative relationship that would continue for the next two and a half months. Daveon engaged through art and other activities such as fishing. We were able to meet at the lake, which was near his home. This activity was symbolic for him because he used to go fishing there with his father, who was now deceased. The lake was a place where he felt safe and was one of the few places where he could feel comfortable enough to share. It was hard to tell whether Daveon was truly an introvert or just highly traumatized. He had been shot in the pelvis, suffered from grief over the recent loss of his father, and could read at only a third- or fourth-grade level.

I provided services at his house, where 10 others lived in one side of a "shotgun" duplex. His large family would often wander in and out of the sessions. I remember one session in particular that entailed painting. His assignment was to paint anything he wanted and to assign feelings to the colors, so that he would have a physical representation of how he felt through a "collage of feelings." His grandmother kept butting into the session, walking in and out of the room and making such comments as "How about rebellious, is there a color for that?" and "What about hard-headed?" Although confidentiality had been discussed, it was not being respected. The session ceased to become therapy in that moment and turned into a simple painting activity because my client, with great reason, shut out any attempts to complete the therapeutic activity.

Counseling in environments such as this can be challenging. It can be difficult to find a confidential space even outdoors, as neighbors and family members may come into and out of the space. Unfortunately, most homes are simply not set up for therapy. Furthermore, liability issues prevent counselors at my agency from being behind closed doors in any given room, so we are required to leave doors open in homes. I found that I needed to be increasingly flexible, careful with confidentiality, and mindful of bringing up sensitive material in an environment that lacks a quiet, safe space. I also found that I needed to adjust my expectations about the depth of work that could occur on a day when there was no space in which to process confidential material. This, of course, is another situation in which it is essential to be mindful of the type of information that is brought up or processed in session.

Environment and Nature of the Work

The environment itself can require the counselor to set personal safety boundaries. In New Orleans, counselors in my agency see clients in many

neighborhoods that present very real physical dangers. I remember a time when I pulled up to the apartment complex where a client lived. I had been to this complex before, and although it was a place I may not want to frequent at night, I had felt safe enough in daylight. Today, however, I immediately felt like something was "a little off." I could not see anything that seemed immediately criminal, so I tentatively approached the door. My anxiety level increased as I remembered that I had my laptop computer in my car. When I stepped inside the apartment, the client's mother told me there had been a shooting about an hour after the last time I had visited. A moment later, the mother asked me if I wanted her to shut the blinds. I left that apartment complex safely, but not without having learned a huge lesson about self-care.

I learned that it is important to take care of ourselves as well as our clients and that going into unsafe situations is not justified. Sometimes it can be difficult to know when and where it is safe or unsafe. In those moments, it is important to trust your intuition and to cautiously navigate each situation out in the field. I continue to work with the client, but now we meet at the park or at McDonald's. I teach skills as well as do counseling, and I do not conduct any therapy sessions at public restaurants. I will, however, engage therapeutically with the child if there is a secluded outdoor space in the park available. The confidentiality issues experienced by "in-home" counselors are challenging, and it is important to be careful and to protect yourself from situations that might be unsafe.

Defining One's Role

The following case example illustrates some struggles with role boundaries that I have experienced:

> Anita, the single mother of five children, had experienced severe domestic violence with her ex-husband, the father to her five children. She had come to rely on the services provided by the agency for counseling and skills training for two of her children. She was a hard-working mother who did everything she could for her children. She pulled me aside one day, desperate for advice on what to do regarding a situation with their father. He was sporadic in his attentiveness toward the children, constantly disappointing them with promises of spending time with them, only for things to "come up" at the last minute. She described his legal right to see them as "visitation within reason," a very ambiguous agreement to say the least. She felt his desperate recent attempts to see them were due to the fact that he had gotten into trouble with the law recently and was using the children to get back in the good graces of a former girlfriend who had pressed domestic violence charges. She was conflicted, as she did not want her children to be used as a manipulative tool by her ex-husband. She had a difficult time separating her own feelings toward her husband with her feelings about whether or not

> it was best for the children to see him under such circumstances. I realized Anita wanted and needed, in that moment, for me to serve not only as her child's counselor but also as her confidant, counselor, or even legal adviser.

This is one of the uncomfortable roles that clients sometimes expect us to fill. It is important in moments like this to provide support but to keep in mind who is being served, the parent or the child. I had to be mindful of how I was serving the children without breaching legal and ethical boundaries. At times it is important for me to define my role by suggesting that parents seek legal counsel or to let them know the counselor is there to serve their children while maintaining a supportive presence in a stressful situation. In these situations, consultation and self-examination are required to stay aware of this important boundary and role definition.

I found it easy to become comfortable with the families I served once the relationship was established. I was often in their homes twice each week. It became apparent to me that when people come to rely on counselors for our services, they may see us as helpers for the entire family, and this is true to the extent that the family affects the child. Things can become comfortable and friendly. I have been in homes at times when food and drink were offered to me. Even gifts have been offered occasionally. When deciding whether or not to accept or reject an offer, I think about the code of ethics, how the offer might affect our future relationship, and also what it means from a cultural perspective. It is important to maintain professional boundaries and at times to define them for clients without damaging the relationship or offending a family's culture.

Fidelity to the Client, Company, and Self

I struggle with the conflicting roles that come with balancing fidelity to the company for which I work with my responsibilities to the client and to myself. As an employee, I am required to provide my clients with a certain number of hours of counseling and psychosocial skills training each week. If a client cancels, I am responsible for making up the appointment the following week. If the appointments are not rescheduled, then the cost of the appointment comes out of my paycheck. I also run the risk of being out of compliance with my job requirements, which could lead to termination. As a result, I find myself being increasingly more flexible when it comes to rescheduling appointments, which often take place in the evenings or on weekends. This can put me in the difficult position of seeing clients at inopportune times. It also weakens the boundaries of professionalism and client responsibility to maintain appointment times.

The safeguards to deal with this issue through my agency are inadequate. Our policy states that if clients do not show up to three appointments they will be terminated from the program. However, I am still responsible for making up the hour that week regardless of who was responsible for

the missed appointment. It has been suggested to me that I could see my more compliant clients more times than clinically necessary in one week to make up the hours. Such a strategy is blatantly unethical because seeing the clients then becomes about the "bottom line" rather than about clients' clinical needs. I refuse to see a client when it is unnecessary to make up for the lack of compliance of another client. This is one of the most difficult situations with which I am faced. There is pressure to make up the hours, but this isn't always realistic or feasible. I often find myself scrambling to make up appointments at the end of the week, which leads to a very real personal boundary violation for me. I am still trying to set solid boundaries in this realm of my life so as to respect my own personal time while staying in compliance with the requirements of my job.

Suggestions

Working for a mental health rehabilitation agency can be challenging, yet it is an important way to serve clients. Clients benefit from seeing a trained therapist multiple times a week. We are in a prime position to advocate for our clients and to comprehensively serve them in the home and the school by coordinating with parents, teachers, social workers, and other agencies involved with the child. This type of work can create some boundary issues in the realms of confidentiality, multiple therapeutic roles, personal boundary challenges, and fidelity to clients. Being aware of these issues can help counselors be more prepared to handle them adequately. Relying on the code of ethics and state laws is imperative to avoid legal and ethical dilemmas. Furthermore, consultation with a supervisors and colleagues inside and outside the job site can help in-home counselors deal with situations that can be difficult to navigate.

Finally, realize that counseling in homes and schools will not always meet the standards of ideal practice in terms of environment but that you can practice in an ethical and effective manner. Being flexible, using training and good clinical judgment, and relying on experienced supervisors and colleagues can help practitioners navigate challenging situations. Self-reflective practitioners can work toward creating better standards, situations, and environments for clients. It is important for counselors who work for agencies that provide in-home counseling services to respectfully advocate for themselves and their clients in schools, in homes, and within the agencies themselves for better work environments, standards, and client care.

A Contributor's Perspective

Clients who are sick, who are not mobile, and who do not have the means to travel to an office may be seen in their homes. Making a home visit or providing counseling in a home often raises boundary concerns, as can be seen in the discussion by Amanda Connell that follows.

Boundary Issues and In-Home Counseling for Clients With Disabilities

Amanda Connell

Establishing and Maintaining Boundaries in In-Home Counseling Settings

As a therapist trainee at a new site, I started an in-home counseling program for people with disabilities who were unable to come to our office. My inspiration for this program comes from having a daughter who is severely disabled. In-home counseling brings therapy services to people who could not otherwise access them, but it is fraught with potential boundary issues—some unique to the home setting and others that are exacerbated by the home setting. This undertaking has been full of valuable learning experiences that continue with the expansion of this program. The following discussion illustrates some of the most significant boundary issues I have experienced in providing in-home therapy services.

Confidentiality and privacy tend to be compromised for this population because of other people being present in the home during sessions. Conversely, when no one else is in the home, clients tend to make numerous requests for assistance outside the scope of the counseling role. These requests may include bringing in the mail, looking for a needed document, getting them a drink, opening windows, and doing other tasks. To a natural caregiver, these requests seem reasonable. However, as my agency has pointed out, these requests all come with some sort of risk of liability. For example, getting the mail or obtaining some item from the house opens us up to suspicion if something goes missing. If we open windows or turn on fans and something breaks in the process, the question of responsibility is raised. Overall, each instance is a judgment call in which I am balancing the requirements of my agency with the needs of the client. It is possible to act in a compassionate and humane manner while maintaining appropriate boundaries with clients. We are very forthright about our purpose and explain what we will and will not do. The agency makes it clear that we are not to attend to personal needs of clients, such as assisting with diapers or medication, which makes sense, as this is far out of the scope of our role as counselors. This may seem obvious, but it is important to formulate guidelines in advance because a natural blurring of boundaries can occur in the home environment where clients are more comfortable. For example, when I arrived for a session the client was partially undressed, which has led us to uniformly inform all new clients that they must be fully dressed for all sessions. I have also noticed that clients tend to answer their phones during sessions at home, which does not happen with clients I see at our office. When clients have roommates, caregivers, or visitors in the house during sessions, we inform clients that it is their right to disclose or not disclose our role as counselors.

This discussion of boundaries should begin during the first phone call to schedule the first session, take place again in the first session, and occur at various times in later sessions. Our agency has established a protocol for in-home sessions that is in addition to all the usual informed consent and rights and responsibilities information, and this has been helpful. We have two counselors attend the first intake session for safety purposes. We ask who else lives in the home, who will be in the home during sessions, and who will let us in upon arrival. Sometimes the client wants the counselor to let herself in because of the client's inability to get to the door. The first time this happened to me, I was unprepared for this. It was disconcerting to arrive and have the client yell for me to just come on in. I did not feel comfortable walking into an unknown client's house and called my supervisor for guidance.

In-home counseling for people with disabilities often requires a fair amount of case management and client advocacy because these clients tend to be more in need of connections to other services in the community. It is important to assist these clients in advocating for themselves through teaching empowerment, modeling a strengths-based perspective, and providing enough support to assist them without taking over in areas of advocacy.

Despite the increased need for clear boundary setting and maintenance, in-home counseling for people with disabilities is a much needed and appreciated service. In addition to the benefit of providing counseling to people who could not otherwise obtain it, a wealth of information is gathered by seeing people in their home environments and through their interactions with others. In-home counseling is an expanding field and one that is both meaningful and rewarding.

Forensic Psychology and Counseling

Psychologists have long been involved in the field of forensic work, and some counselors specialize in working with criminal offenders. With the large number of incarcerated individuals and the heightened focus on solving the problems of violent crime—including violent behavior among teenagers, workplace violence, and murder—more psychologists and counselors are entering the forensic psychology field than ever before. Psychology graduate programs have historically provided broad-based training in psychology, but more graduate school programs today focus on specialty fields such as forensic psychology.

A Contributor's Perspective

In the following contribution, Robert Haynes and Stacy L. Thacker draw on their combined clinical forensic work experience spanning 44 years, including 31 years guiding clinical and counseling doctoral-level students through an internship program in a forensic inpatient setting. They describe some of the challenges of managing multiple relationships in such settings.

Managing Multiple Relationships in a Forensic Setting

Robert Haynes and Stacy L. Thacker

In forensic settings, therapeutic boundaries are often unclear, and the roles of the psychologist or counselor are multiple and complex. The mental health professional in forensic settings serves in a variety of roles and may be called upon to be therapist, evaluator, security enforcer, case manager, expert witness, and predictor of future dangerousness, all for the same individual.

A common dilemma for the forensic practitioner is to determine who is the actual client (Lyon & Ogloff, 2000). Is it the incarcerated individual, the court system, the state, the victim, or society? For whom, and for whose good, is the practitioner working? Whose goals take priority when conducting therapy? The courts may have mandated therapy to help the individual become a law-abiding citizen, but the offender may want to focus on lessening his guilt about having committed a crime. Is it the therapist's role to help the individual work for what he or she wants or to follow the court's mandate? It is crucial for the therapist to have a thorough understanding of the boundaries of the relationship and which goals take priority before engaging in a professional relationship with the forensic client.

Confidentiality in the true sense is nearly impossible given that the professional is most likely working for the court system, probation, or the state. Although a trusting relationship is essential in therapy, it is difficult to achieve in a forensic setting. Therapists can, however, identify with the individuals those topics that can remain confidential in the therapy relationship and those that cannot. It is then the individual's choice whether to delve into areas that cannot be kept confidential. Sometimes an incarcerated individual will venture into the nonconfidential area to test what the therapist will do and to help the offender determine whether or not the therapist can be manipulated into keeping secrets. Once the therapist keeps confidential any information that should be reported, the therapist has crossed the boundary of the therapeutic relationship and will most likely see an escalation of unusual requests and demands by the offender.

When working as psychologists on inpatient units, we held group and individual therapy sessions for many individuals on the unit. Because each of us has functioned as the only psychologist on a unit, we were often called upon to conduct psychological evaluations of individuals for the purpose of making recommendations to the court regarding individuals' readiness for release into the community. The dilemmas that we faced involved the ethical issue of being both therapist and evaluator for the same individuals and keeping straight the information we had received in the therapeutic setting from the information we had received while conducting an evaluation. It seems simple to say that one should not function in these multiple roles, yet the workload at the facility and the demands of the courts were substantial.

The *Specialty Guidelines for Forensic Psychology* (APA, American Psychology-Law Society & Division 41, 2011) addresses this ethical issue:

> Therefore, when requested or ordered to provide either concurrent or sequential forensic and therapeutic services, forensic practitioners are encouraged to disclose the potential risk and make reasonable efforts to refer the request to another qualified provider. If referral is not possible, the forensic practitioner is encouraged to consider the risks and benefits to all parties and to the legal system or entity likely to be impacted, the possibility of separating each service widely in time, seeking judicial review and direction, and consulting with knowledgeable colleagues. When providing both forensic and therapeutic services, forensic practitioners seek to minimize the potential negative effects of this circumstance (Ethical Principles of Psychologists and Code of Conduct [EPPCC] Standard 3.05). (Section 4.02.01)

The demands of many forensic settings require a model of practice in which the practitioner serves in multiple roles, which can lead to somewhat unique ethical concerns (Strasburger, Gutheil, & Brodsky, 1997). Practitioners should make every effort to minimize conflicts of interest and avoid multiple roles. For example, the practitioner might trade the provision of psychological evaluations with another psychologist to avoid providing both therapy and evaluation with the same individual. However, heavy workloads can make such practice overly burdensome. Also, therapists must be prepared to identify instances in which the nature of the situation requires them to excuse themselves from one or more roles. Again, the demands of the institution or system in which the practitioner works may make this a difficult endeavor at best.

Countertransference issues also affect therapeutic boundaries in working with forensic populations. It is important for forensic psychologists and counselors to understand what can and cannot be accomplished with a criminal offender. Training in psychology often involves learning to support individuals and fostering a trusting, caring relationship. We may wish to be helpful and nurturing. Sometimes this caring and nurturing can be counterproductive with offenders and may open the door for the offender to manipulate both the therapist and the system (Young, Justice, Erdberg, & Gacono, 2000). Support, trust, and caring should be moderated with caution, objectivity, and a watchful eye for manipulation. In particular, working with antisocial or psychopathic offenders requires a more structured, sometimes confrontive, and always cautious approach, as such individuals often engage in treatment with hidden agendas or unspoken objectives.

It is not uncommon for helping professionals in forensic settings to feel dislike, disgust, and even repulsion toward some individuals because of the heinous crimes they have committed (Reeder & Schatte, 2011). These feelings can lead professionals to become more comfortable in the role of security enforcer and less comfortable in the role of therapist. Practitioners

may even feel frightened of the individuals they treat because of these individuals' violent histories (Gordon & Kirtchuk, 2008). The practitioner must be constantly aware of the potential for such feelings and remain alert to keep these feelings from compromising his or her work with a particular individual or group of individuals. According to Mobley (1999), therapists who are most likely to be successful in working with forensic populations are those who can empathize without sympathy, confront without demeaning, care without carrying the individuals' burdens, direct without controlling, and see manipulation as a poor coping strategy rather than as a personal assault. Successful forensic practitioners find satisfaction in erratic progress toward limited goals, can tolerate the ambiguities and conflicts of the treatment setting, and accept the limitations of that setting so that they do not burn out or become disillusioned.

Practitioners are often faced with judgment calls that require an ability to foresee potential consequences of their decisions. One such consequence may be that the individual receiving treatment or being evaluated may be seeking to manipulate the practitioner for secondary gain. This possible consequence becomes even more likely when working with personality disordered individuals (Evershed, 2010; R. D. Miller & Maier, 2002). For some practitioners this may be a reversal of the usual concerns regarding power dynamics between practitioners and treatment recipients, which have historically focused more on the practitioner using a position of power over the individual receiving treatment. In this case, the individual seeks to secure a position of power over the practitioner in order to manipulate the practitioner to his or her advantage. To give an example, an individual with a significant number of antisocial or psychopathic personality traits working with a practitioner toward gaining better insight into his or her antisocial attitudes and behaviors asks the practitioner to share documents from the individual's chart or file rather than follow the agency's policies and procedures for accessing such documents. Although this may appear to be a minor request and perhaps pertinent to the therapeutic goals, if the request violates institutional rules, the practitioner who complies with the request has colluded with the individual and broken the rules. Also, because the practitioner has broken this seemingly minor rule, the demands from this individual are likely to escalate to more serious violations of institutional policies with threat from the individual to expose the practitioner's previous violation if he or she does not comply with the new demand. In fact, this may be characteristic of the kind of antisocial behavior that led to the individual's arrest—minor violations that escalated over time.

Not every therapist is suited to work with criminal offenders. Recommendations for psychologists and counselors working in a forensic setting include the following:

- Know your strengths and limitations in working with a forensic population and within a particular setting or role.

- Be aware of how your own values and countertransference issues affect your work with offenders.
- Utilize colleagues and supervisors as consultants to provide feedback regarding difficult cases or issues.
- Be realistic about what goals can and cannot be achieved in a particular setting or with a particular individual or group of individuals.
- Take care of your own mental health. Forensic work can be challenging, exhausting, frustrating, and demanding.
- Remember that safety and security must be priorities, sometimes at the expense of treatment.
- Become familiar with the standards and principles that apply specifically to forensic psychology, such as APA's (2011) *Specialty Guidelines for Forensic Psychology.*

Concluding Comments

We have found working with forensic clients to be interesting, challenging, intense, and at times exhausting. We are routinely exposed to negativity in hearing from criminals about their lives, their crimes, and their victims. As forensic psychologists, we evaluate these individuals for treatment, for release to the community, and for their risk of reoffending. We also provide treatment to help these individuals change their thinking and behavior with the goal of helping them live more productive lives as well as the goal of preventing them from reoffending. When evaluating for release, in particular, the individual's task is to look as good as possible and convince us that he or she will be a low risk to the community if released. Sometimes that means we will be lied to, manipulated, and deceived, so we are always on alert for such behavior. Individuals may also lie, manipulate, and deceive us to obtain some desired privilege or item not readily accessible within the restricted settings in which they live. This line of work makes our attention to relationship and boundaries issues within the forensic setting especially critical and demanding. We must be clear, firm, and consistent about where our boundaries lie. If boundaries are clearly established and maintained, work with forensic clients can be effective and rewarding.

Conclusions

This chapter focused on several distinct specialty areas of practice. They are quite different from one another, yet they share these commonalities: Dual and even multiple roles are inherent in the nature of the work, and practitioners need to assume some nontraditional roles if they are to serve their client populations effectively. Certainly, practitioners of many other counseling specialties confront similar issues, and we invite you to consider how the points raised by our chapter contributors might be applied

to your own work. For instance, many counselors do not consider themselves specialists in forensic work, but they may experience role conflicts when they find themselves involved with the legal system as part of their work with a client. Brad Johnson offered recommendations for managing multiple relationships in the military. It is likely that you will find ways to apply some of his recommendations to your own setting.

This chapter concludes our examination of multiple role and relationship issues in counseling practice. We have touched on many specialty areas, but others might just as easily have been included. We have raised representative issues and discussed strategies and solutions that we hope all practitioners can relate to and apply in their work.

Chapter 12

Key Themes, Questions, and Decision Making

In this concluding chapter, we highlight some key concepts or themes that have emerged throughout the book and present questions for reflection and integration. We also offer a model of a decision-making process that we find helpful when confronted with potential multiple relationships.

Eleven key themes (or concepts) have been woven throughout the tapestry of this work.

Key Themes

Very few helping professionals remain untouched by potential multiple role conflicts and dilemmas. We have examined how these relationships affect professionals who work with individual clients, couples, families, and groups in many settings and in a number of specialty areas of practice. We also examined the complex questions that arise when relationships are tripartite, such as those involving supervisor, supervisee, and client or consultant, consultee, and client systems. We have covered a broad range of boundary issues in this book, and we believe that dual and multiple role conflicts and concerns are indeed pervasive in the mental health professions. We now turn our attention to some common themes and the complex considerations required to practice aspirational ethics as we work with clients from all walks of life.

1. *Most professional codes of ethics caution against forming dual relationships that have the potential to cause harm, but current codes also acknowledge the complex nature of these relationships.*
   Consulting the codes of ethics can be helpful when we look for guidance regarding multiple relationship dilemmas. However, it seems

clear to us that codes of ethics cannot provide the answers to most of the questions counselors face. A crucial ethical principle that applies to all potential multiple relationships is to do no harm: Do not exploit, and do not misuse power. Multiple relationships per se are not necessarily harmful; rather, it is the power differential that creates a potential for exploitation. As professionals, it is our ethical responsibility to devise safeguards to prevent harm to clients, students, supervisees, or others who are in the less powerful position and may be involved in dual or multiple relationships with us. At the same time, it is imperative that we involve clients, students, and supervisees in open discussion regarding the possible risks and benefits of any dual relationship we consider entering. For students, seasoned practitioners, and clients alike, learning to deal with boundaries and role conflicts can help us appreciate the complexity in human relationships.

2. *Not all multiple relationships (and boundary crossings) can be avoided, nor are they necessarily always harmful, and they can be beneficial.*
   Multiple relationships are fraught with complexities and ambiguities, and they contain potential for both risk and benefit to clients. Dual and multiple relationships, and some boundary crossings, are unavoidable in most settings, including in rural and small communities, in counselor education programs, in the military, in crisis and disaster work, and in addictions counseling treatment programs. Counselors who work in these kinds of settings will need to develop a high comfort level with frequent boundary crossings, and they will need to manage these boundaries rather than avoid them.

   Some forms of role blending can be beneficial, such as the mentoring relationships between professor and student or the teaching of group counseling courses by combining didactic and experiential learning experiences.

3. *Multiple role relationships challenge us to monitor ourselves and to examine our motivations for our practices.*
   As practitioners, we need to engage in an ongoing process of self-reflection based on these three questions: What is the right thing to do? Am I doing the right thing? Am I doing the right thing for the right reason? It is all too easy to deceive ourselves into thinking that we have the best interests of our clients in mind. One example that we offered was that of a private practitioner who encourages clients in individual therapy to join a group that the practitioner is forming. This may not be what clients need, and if we are not honest with ourselves, we run the risk of exploiting our clients. Whenever a multiple role issue arises, it is essential that we ask ourselves whose needs are being met.

4. *There are few absolute answers that can neatly resolve dual or multiple relationship dilemmas.*
   Rather than thinking in terms of "finding the answer," consider the possibility that there may be more than one acceptable way to

respond to the ethical dilemmas that arise from engaging in multiple relationships. Answers that may be appropriate for us may not be appropriate for you in your situation. The therapeutic styles and preferences of the practitioner, the unique needs of each client, and the cultural context must be taken into account when evaluating boundary crossings and multiple relationships. Counselors need to be able to tolerate ambiguity, and we will not find security in the absolute answers that some others may be quick to offer us.

5. *Deciding whether to enter into dual or multiple relationships should be based on benefitting our clients or others served rather than protecting ourselves from censure.*
   Mental health professionals continue to be sued for malpractice, most often in regard to unethical boundary violations such as sexual relationships with clients. Fear of lawsuits, ethics complaints, or censure from a licensing board should not drive our decisions. The needs of our clients and our ethical reasoning skills provide the foundation from which we should evaluate potential multiple roles and relationships. In the final analysis, there is no substitute for our professional judgment, integrity, and goodwill.
6. *In determining whether to proceed with a dual or multiple relationship, or to cross a boundary, consider whether the potential benefit of the relationship outweighs the potential for harm.*
   Generally, dual relationships may be entered into only when the risks of harm are small or when there are strongly offsetting ethical and clinical benefits for the client. It is prudent to consider the risks to the client and the professional involved as well as the possible effects on other consumers, other professionals, the profession itself, and society. Although we may identify benefits to engaging in certain multiple roles or crossing certain boundaries, we must be cautious in proceeding.
7. *Whenever we consider becoming involved in a dual or multiple relationship, it is wise to seek consultation from trusted colleagues or a supervisor.*
   A willingness to seek consultation and to document this process are signs of professionalism. We may also save ourselves a costly and painful malpractice judgment if we are able to demonstrate that we acted in good faith, sought consultation, and practiced within an acceptable standard of care. It is a good practice to seek consultation from more than one professional, and it can be useful to ask for help from colleagues who may have a different philosophy or perspective than you do. Colleagues with a range of perspectives can provide useful insights on potential problem areas that you may have overlooked. They can also help us maintain our objectivity and can enhance our ability to appraise situations honestly. Documenting our decision-making process, our actions, and our rationale for our actions is a wise step to take. It is good to keep in mind the often-cited dictum, "If it is not documented, it did not happen."

8. *Boundary issues must be considered within their cultural context.*
   Our views on multiple relationship issues need to be broadened to incorporate culturally appropriate boundaries. Multiculturally competent counselors modify their practices to meet the needs of diverse clients. They identify culturally sensitive ways to address questions about self-disclosure, giving and receiving gifts, sharing meals or other social activities with clients, and interacting with clients outside the traditional office setting. Counselors often serve as advocates and partners with clients to facilitate social justice and healing within the context of the client's community.
9. *Supervisors operate in multiple roles as teacher, mentor, consultant, counselor, sounding board, adviser, administrator, evaluator, and documenter.*
   Supervisors may serve many different functions during a single supervisory session. They might instruct a supervisee in a clinical approach, act as a consultant on how to intervene with the client, act therapeutically in helping the supervisee with countertransference issues, and give evaluative feedback to the supervisee regarding his or her progress as a counselor. Supervisors have a position of influence with their supervisees, and they take steps to prevent the misuse of this power that could lead to harm or exploitation of their supervisees. If there is a frank discussion at the beginning of the supervisory relationship about the mutual responsibilities of supervisors and supervisees, expectations can be clarified and conflicts are less likely to develop at a later time. As a part of the informed consent discussion, supervisors can explain that supervision is a complex process and that supervisors are required to function in multiple roles.
10. *It is the responsibility of counselor education programs to introduce the topic of boundary crossings and explore multiple relationship questions with students.*
   It is important to teach students ways of thinking about alternative courses of action. When students first enter their graduate program in the helping professions, they may have given little thought to the complexities involved in multiple relationships. Lazarus and Zur (2002) assert that training programs tend to instill a fear of malpractice and do not give enough attention to educating trainees about personal integrity; personal ethics; and how to navigate the complex issues of dual relationships, boundaries, and intimacy in therapy. We suggest that the issues we have raised in this book be discussed extensively in ethics courses and in courses such as group supervision, practicum, and internship. When students are involved in supervised field placements, they are bound to encounter some dilemmas related to maintaining boundaries with their clients. As counselor educators and supervisors, we do well to encourage students to bring their concerns about these dilemmas to us for discussion. We

can also introduce issues through case vignettes and role-playing exercises. Counselor educators should do more than provide students with a list of dos and don'ts. They can challenge students to think through their own positions on issues.

11. *Counselor education programs have a responsibility to develop their own guidelines, policies, and procedures for dealing with multiple roles, dealing with role conflicts, and managing boundaries within the program.* Faculty should be engaged in continuing discussion about ways to prevent harmful dual relationships within the training program. As educators and supervisors, we must be able to deal with multiple relationships effectively if we hope to teach students how to deal with these matters. If we are not modeling effective ways of thinking about and managing boundary considerations, how can we expect our students to grapple constructively with them? Faculty groups, with student representation, can develop practical guidelines and procedures in a proactive manner.

Questions for Reflection and Integration

Throughout this book, in each chapter, we have tried to involve you, our readers. Many questions were raised to encourage you to think about the topics explored in these chapters. Here we summarize some of the questions that have recurred in various forms. As you review this list, consider your own stance toward the issues and the ways they affect your work as a professional.

- Are *sexual relationships with former clients* (or students or supervisees) ever ethically acceptable? If so, do you think it is a good idea to establish a minimum 5-year time period between terminating the professional relationship and beginning the personal one? What about *social relationships or friendships with former clients* or collegial or peer relationships with former students or supervisees?
- How should the mental health professions deal with the issue of *sexual attraction* between counselors and clients? How can counselor education programs prepare prospective counselors so that they are able to distinguish clearly between feeling a sexual attraction and acting on that attraction? How can sexual attractions best be managed?
- What steps can the profession take to *prevent sexual improprieties* with clients, students, or supervisees? What is your own role in prevention?
- Do the *codes of ethics* that govern your professional identity, work setting, and clientele address boundary considerations and multiple relationships in a way that is helpful to you? What guidelines would be useful for you in making decisions?

- If you are a *graduate student*, what kinds of training do you want to receive so that you feel prepared to cope with managing boundaries and multiple relationships? What kinds of relationships do you want—and not want—to have with your professors?
- What are the appropriate boundaries of a *supervisor's role*? Can supervision address personal concerns of the supervisee without creating a dual role conflict? What kind of boundaries between counseling and supervision are useful?
- Is *bartering* with clients for goods or services ever acceptable to you in your practice? If so, under what circumstances is it acceptable? If you would not barter, what alternatives might you suggest to clients who are in great financial need?
- What are your thoughts about *accepting a gift* from a client? What factors are you likely to consider in deciding whether to accept a gift?
- What guidelines can you apply to determine the appropriate limits of *counselor self-disclosure*? What boundary issues might be created for you in your work if you were to overextend these limits?
- What kinds of experiences and training would be helpful for you to receive so that you can learn to assume alternative roles to the traditional roles of a counselor?
- What are some ways the traditional notions about boundaries may need to be reassessed so counselors can become advocates for clients and promote social justice?
- What special role conflicts do you encounter when you function as a *supervisor or consultant*? To whom do you owe your first obligation—to your supervisee or consultee, or to the client who is ultimately served? What role conflicts do you encounter in attempting to balance these obligations?
- If you were asked to provide services for clients *outside the traditional office setting*, what boundary issues do you think you would encounter, and how would you manage them?
- If you function in *multiple roles* in your work—in any combination of such roles as counselor, supervisor, administrator, teacher, client advocate, case manager, colleague, or group leader—what role conflicts do you most frequently encounter? How do you resolve them?

A Decision-Making Model

As a result of examining and pondering these questions, we have developed a model decision-making process that can be useful when confronting dual or multiple relationship dilemmas (see Figure 12.1).

Boundary crossings are sometimes confused with dual relationships. Lazarus and Zur (2002) and Zur (2004, 2014) maintain that boundary crossings are not unethical and, in some circumstances, may constitute caring, humane, and effective interventions. A few examples of such boundary

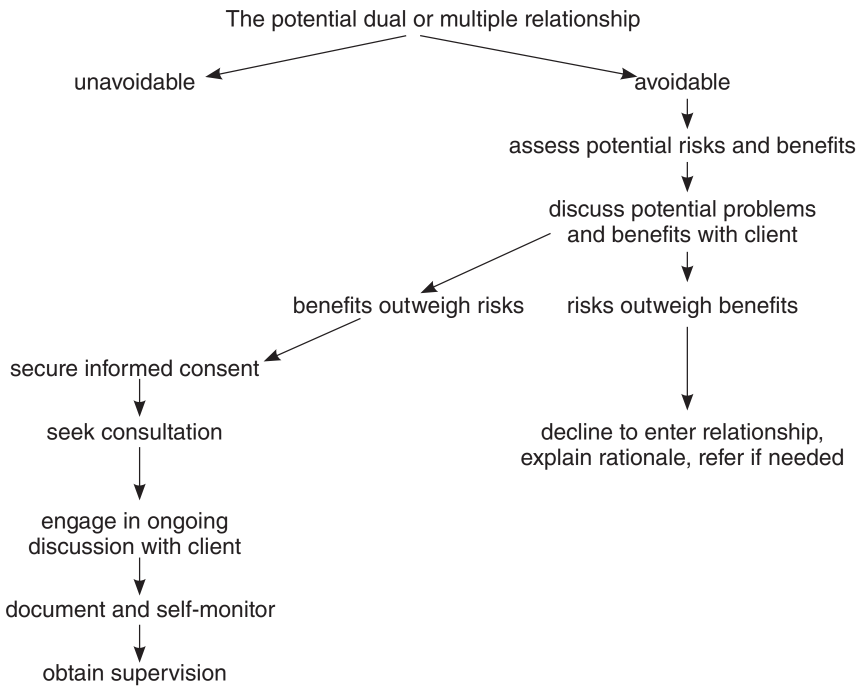


Figure 12.1 **The Potential Dual or Multiple Relationship**

crossings might include conducting a home visit with a client who is ill, having lunch with a client with an eating problem, going on a vigorous walk with a depressed client, or attending an event where the client is performing. The *ACA Code of Ethics* (American Counseling Association, 2014) acknowledges these types of interactions with clients as being "potentially beneficial." Counselors need to engage in a decision-making process in determining when boundary crossings are appropriate and therapeutic.

It seems clear to us that some dual or multiple relationships, built into the counselor's job description or dictated by the unique needs of clients, are indeed unavoidable. Examples include the rehabilitation counselor who must manage the client's case budget; the counselor in a rural community whose clients are also her banker, beautician, and pharmacist; and the school counselor who must report child abuse and then continue to function as the child's counselor and liaison with Child Protective Services. In these and similar instances, the professional's obligation is to take all possible steps to minimize the risks of harm. Securing the client's informed consent is an ethically important first step that entails a full and open discussion with the client in which the risks are explored. Counselors who are engaged in unavoidable dual or multiple relationships are advised to seek consultation both at the time the relationship is entered into and periodically throughout its duration. Ongoing self-monitoring

and documentation are additional prudent measures. When unavoidable dual or multiple relationships become problematic, it is wise to obtain supervision.

Other types of role blending are avoidable, and in these cases the professional has a choice as to whether to engage in blended or multiple roles. Here it is essential that potential risks and benefits be carefully weighed. A judgment needs to be made regarding factors that create a potential for harm, including differences in expectations, divergent responsibilities, and the power differential. In some instances, when the potential benefits are great and the risks are small, the professional may decide to proceed. Just a few examples include serving as a mentor to a student; teaching a group counseling class in a way that combines didactic and experiential learning; and working with a client who is near the end of life, and the client's family, in a nontraditional, out-of-office environment.

In yet other cases, careful consideration of potential risks will lead the professional to conclude that it is best not to enter into a dual or multiple relationship because the risk of harm is great. Examples include entering into a close, personal friendship with a current client, student, or supervisee or entering into a business relationship with a client. When a potential dual or multiple relationship can and should be avoided, professionals need to take steps to ensure that clients understand the rationale for not proceeding with the problematic aspect of the relationship. For instance, in the first example, this might involve acknowledging the attractiveness of the idea of a friendship, discussing the risks to the counseling relationship if a friendship were to develop, and mutually agreeing on what the boundaries of the professional relationship will be.

Although the decision-making model helps to clarify our thinking, each of us will encounter situations in our work that will raise difficult questions for which the answers remain elusive. In our view, the ability of mental health professionals to reason through ethical issues can be strongly tested by conflicting roles and multiple relationship situations. As is the case with learning to make ethical decisions in other areas of professional practice, many of these situations defy easy answers. To some degree, the personal style of each counselor will dictate the resolution of multiple relationship dilemmas. Some practitioners may be comfortable practicing in the context of multiple roles, but others may need to establish more clear-cut boundaries.

Conclusions

Coauthoring this work about dual or multiple relationships has been a learning experience for both of us. During the revision process, we discovered new slants on issues we have contemplated over the years, rethought many issues in the context of various updated ethical standards, and broadened our perspectives through working with our guest contributors.

Certainties are rare in the helping professions. We make no claim to having discovered answers to the complex and difficult questions about professional relationship boundaries. Rather, our aim has been to raise some important professional concerns, to explore a range of viewpoints, and to discuss our own positions. In writing the various chapters, we hoped to provide material for thoughtful reflection that would act as a springboard for ongoing discussion. We expect that ethically conscientious professionals will continue to struggle with the multiple relationship dilemmas that they face and the multiple roles they will be expected to balance in their work. In the absence of certainties, we must rely on our reasoned professional judgment, openness to discussing issues with clients (or students or supervisees) who are equally affected by the decisions made, and consultation with colleagues. Instead of searching for definitive answers to many of the multiple roles and responsibilities associated with counseling practice, the real challenge is to learn a process of thinking about such dilemmas and clarifying our rationale for the decisions we make in our professional practice.

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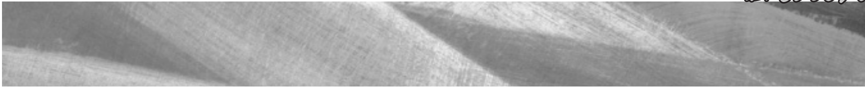

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