1

BOUNDARY ISSUES AND DUAL RELATIONSHIPS

Key Concepts

CONSIDER THE FOLLOWING case scenarios and imagine yourself as the human service professional. How would you handle the boundary issues in these circumstances?

- Tanya M., a counselor employed in a community mental health center, provides services to clients with chronic mental illness. One of her clients, who is being treated for bipolar disorder, has been abusing alcohol and cocaine. Tanya encouraged the client to begin attending twelve-step meetings. The client decides to attend a local meeting that she chose from a list of area meetings. At the meeting the client encountered Tanya, who has been in recovery for nearly nine years. Tanya was surprised to see her client at the meeting and had to decide whether to stay in the meeting and whether to speak at the meeting in front of her client.
- Belinda K. was a case manager at a family service agency. She developed a good working relationship with a client, Theresa B., who was referred to the agency after she was released from prison on parole. Theresa deeply appreciated the help she received from Belinda and decided to give Belinda a gift—a bracelet worth about twenty dollars. Belinda had to decide whether to keep the gift. One concern she had was that Theresa would be offended if Belinda returned the gift. However, Belinda's agency had a policy that prohibited staff from accepting gifts from clients.
- Stephen M. was a counselor in private practice. One of his clients, Daphne F., a religious woman, asked Stephen to please spend time with her reading passages from the Bible. Stephen was not particularly religious but thought it might be therapeutically helpful to Daphne to read the Bible with her. Stephen wasn't sure whether it would be appropriate for him to read the Bible with Daphne.

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■ Phoebe W. was a social worker at an outpatient counseling program for adolescents. One of Phoebe's clients, Anna, sixteen, struggled with issues of depression and marijuana abuse. Over time Phoebe and Anna developed a strong therapeutic alliance. During one clinical session Anna asked Phoebe whether she had smoked marijuana as a teenager and whether Phoebe had ever gotten high. Phoebe was unsure whether to respond candidly about her own drug use as a teenager. In addition, Anna asked Phoebe to "friend" her on Facebook.

■ Phil C. was a counselor in a group private practice. Phil provided counseling services to a young man, Dwayne L., who was struggling with anxiety. Dwayne worked hard in treatment and terminated after about seven months. Phil and Dwayne had an excellent therapeutic relationship. Nearly seven years later Phil and Dwayne encountered each other, entirely by coincidence, at a mutual acquaintance's holiday party. Phil and Dwayne thoroughly enjoyed reconnecting. Phil and Dwayne enjoyed each other's company so much that they talked about getting together again socially. A couple of colleagues in Phil's peer consultation group expressed concern about his entering into a relationship with a former client.

In recent years human service professionals have developed an increasingly mature grasp of ethical issues in general and, more specifically, boundary issues (Reamer 2006c). The professional literature has expanded markedly with respect to identifying ethical conflicts and dilemmas in practice; developing conceptual frameworks and protocols for ethical decision making when professional duties conflict; and formulating risk-management strategies to avoid ethics-related negligence and ethical misconduct (Barnett and Johnson 2008; Barsky 2009; Bernstein and Hartsell 2008; Bersoff 2008; Congress 1999; Corey, Corey, and Callanan 2010; Gray and Webb 2010; Koocher and Keith-Spiegler 2008; Loewenberg, Dolgoff, and Harrington 2008; Nagy 2010; Pope and Vasquez 2010; Reamer 2003a, 2006a–b, 2009a; Wilcoxon, Remley, and Gladding 2011).

Clearly, ethical issues related to professional boundaries are among the most problematic and challenging. Briefly, boundary issues arise when human service professionals encounter actual or potential conflicts between their professional duties and their social, sexual, religious, collegial, or business relationships (DeJulio and Berkman 2003; Gutheil and Gabbard 1993; Reamer 2008a–b, 2009a–c; St. Germaine 1993, 1996; Syme 2003; Zur 2007). As I will explore more fully later, not all boundary issues are problematic or

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unethical, but many are. My principal goal is to explore the range of boundary issues in the human services, develop criteria to help professionals distinguish between boundary issues that are and are not problematic, and present guidelines to help practitioners manage boundary issues and risks that arise in professional work.

BOUNDARY ISSUES IN THE HUMAN SERVICES

Human service professionals—be they clinicians (social workers, psychologists, mental health counselors, psychiatrists, marriage and family therapists, psychiatric nurses, pastoral counselors), case managers, administrators, community organizers, policy makers, supervisors, researchers, or educators—often encounter circumstances that pose actual or potential boundary issues. Boundary issues occur when practitioners face potential conflicts of interest stemming from what have become known as dual or multiple relationships. According to Kagle and Giebelhausen, "A professional enters into a dual relationship whenever he or she assumes a second role with a client, becoming social worker and friend, employer, teacher, business associate, family member, or sex partner. A practitioner can engage in a dual relationship whether the second relationship begins before, during, or after the social work relationship" (1994:213). Dual relationships occur primarily between human service professionals and their current or former clients, between professionals and their clients' relatives or acquaintances, and between professionals and their colleagues (including supervisees, trainees, and students).

Historically, human service professionals have not generated clear guidelines regarding boundaries for use in practice. This is partly because the broader subject of professional ethics—to which the topic of boundaries is closely tied—did not begin to receive serious attention in the scholarly and professional literature until the early 1980s. In addition, the human services field, starting with Freud, is rife with mixed messages related to boundaries and dual relationships (Gutheil and Gabbard 1993). Freud sent patients postcards, lent them books, gave them gifts, corrected them when they spoke inaccurately about his family members, provided some with considerable financial support, and on at least one occasion gave a patient a meal (Gutheil and Gabbard 1993; Lipton 1977; Syme 2003). According to Gutheil and Gabbard,

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> The line between professional and personal relationships in Freud's analytic practice was difficult to pinpoint. During vacations he would analyze Ferenczi while walking through the countryside. In one of his letter to Ferenczi, which were often addressed "Dear Son," he indicated that during his holiday he planned to analyze him in two sessions a day but also invited him to share at least one meal with him each day (unpublished manuscript by A. Hoffer). For Freud the analytic relationship could be circumscribed by the time boundaries of the analytic sessions, and other relationships were possible outside the analytic hours. The most striking illustration of this conception of boundaries is Freud's analysis of his own daughter, Anna.
>
> (1993:189)

These various manifestations of blurred boundaries occurred despite Freud's explicit and strongly worded observations about the inappropriateness of therapists' love relationships with patients: "The love-relationship actually destroys the influence of the analytic treatment on the patient; a combination of the two would be an inconceivable thing" (Freud 1963, cited in Smith and Fitzpatrick 1995).

Several other luminaries have provided intriguing mixed messages regarding boundaries. When Melanie Klein was analyzing Clifford Scott, she encouraged him to follow her to the Black Forest for her vacation. During each day of the vacation, Klein analyzed Scott for two hours while he reclined on the bed in Klein's hotel room (Grosskurth 1986; Gutheil and Gabbard 1993). Klein also analyzed her own children (Syme 2003). D. W. Winnicott (1949) reported housing young patients as part of his treatment of them. According to Margaret Little's (1990) first-person account of her analysis with Winnicott, he held her hands clasped between his for many hours as she lay on the couch. Little also reports that Winnicott told her about another patient of his who had committed suicide and disclosed significant detail about his countertransference reactions to the patient. Winnicott also apparently routinely concluded sessions with coffee and biscuits. Carl Jung reportedly had close and loving relationships with two of his patients who later became his students (Syme 2003).

Further complicating efforts to develop definitive guidelines regarding proper boundaries is the contention by a relatively small number of critics that the human service professions have mishandled their efforts to generate boundary-related guidelines and that current prohibitions are too simplistic. In one of the earlier critiques Ebert, for example, argues that "the concept

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of dual relationship prohibitions has limited value in that it creates confusion and leads to unfair results in ethics and licensing actions. It serves little purpose because it does not assist psychologists in analyzing situations. Neither does it provide much help in assisting psychologists in deciding how to act in a particular situation, such that the client's best interest in considered" (1997:137). Ebert asserts that many dual relationship prohibitions enforced by the American Psychological Association during that era—especially those related to nonsexual relationships—violate practitioners' constitutional and privacy rights and are overly vague.

The contemporary human service literature contains relatively few in-depth discussions of boundary issues and guidelines. Understandably, much of the available literature focuses on dual relationships that are exploitative in nature, such as the sexual involvement of clinicians with their clients (Celenza 2007; Gabriel 2005; Gerson and Fox 1999; Gutheil and Brodsky 2008; Herlihy and Corey 2006; Olarte 1997; K. Pope 1991; Simon 1999; Syme 2003). Certainly, these are important and compelling issues. However, many boundary and dual relationship issues in the human services are much more subtle than these egregious forms of ethical misconduct (Lamb, Catanzaro, and Moorman 2004; Lazarus and Zur 2002; Moleski and Kiselica 2005; Younggren and Gottlieb 2004). A pioneering empirical survey of a statewide sample of clinicians uncovered substantial disagreement concerning the appropriateness of such behaviors as developing friendships with clients, participating in social activities with clients, serving on community boards with clients, providing clients with one's home telephone number, accepting goods and services from clients instead of money, and discussing one's religious beliefs with clients (Jayaratne, Croxton, and Mattison 1997; also see Borys and Pope 1989; Pope, Tabachnick, and Keith-Spiegel 1988; Strom-Gottfried 1999). As Corey and Herlihy note,

> The pendulum of controversy over dual relationships, which has produced extreme reactions on both sides, has slowed and now swings in a narrower arc. It is clear that not all dual relationships can be avoided, and it is equally clear that some types of dual relationships (such as sexual intimacies with clients) should always be avoided. In the middle range, it would be fruitful for professionals to continue to work to clarify the distinctions between dual relationships that we should try to avoid and those into which we might enter, with appropriate precautions.
>
> (1997:190)

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To achieve a more finely tuned understanding of boundary issues, we must broaden our analysis and examine dual relationships through several conceptual lenses. First, human service professionals should distinguish between boundary violations and boundary crossings (Gutheil and Gabbard 1993). A boundary violation occurs when a practitioner engages in a dual relationship with a client or colleague that is exploitative, manipulative, deceptive, or coercive (Glass 2003; Gutheil and Simon 2002; Johnston and Farber 1996). Examples include practitioners who become sexually involved with clients, recruit and collude with clients to fraudulently bill insurance companies, or influence terminally ill clients to include their therapist in their will.

One key feature of boundary violations is a conflict of interest that harms clients or colleagues (Anderson and Kitchener 1998; Baer and Murdock 1995; Celenza 2007; Epstein 1994; Gabbard 1996; Gutheil and Brodsky 2008; Kitchener 1988; Kutchins 1991; Peterson 1992; K. Pope 1988, 1991; Syme 2003). Conflicts of interest occur when professionals find themselves in a relationship that could prejudice or give the appearance of prejudicing their decision making. In more legalistic language, conflicts of interest occur when professionals are in "a situation in which regard for one duty leads to disregard of another or might reasonably be expected to do so" (Gifis 1991:88). Thus a human service professional who provides services to a client with whom he would like to develop a sexual relationship faces a conflict of interest; the professional's personal interests clash with his professional duty to avoid harming the client. Similarly, a practitioner who invests money in a client's business is embedded in a conflict of interest; the professional's financial interests clash with her duty to the client (for example, if the professional's relationship with the client becomes strained because they disagree about some aspect of their shared business venture).

The codes of ethics of several human service professions explicitly address the concept of conflict of interest. A prominent example is the National Association of Social Workers' (NASW) *Code of Ethics* (2008):

> Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may

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> require termination of the professional relationship with proper referral of the client.
>
> (standard 1.06[a])

The NASW code goes on to say that "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" (standard 1.06[c]).

The *American Association for Marriage and Family Therapy Code of Ethics* (2001) conveys similar guidance with regard to this profession's narrower focus on counseling relationships:

> Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions.
>
> (standard 1.3)

Some conflicts of interest involve what lawyers call *undue influence*. Undue influence occurs when a human service professional inappropriately pressures or exercises authority over a susceptible client in a manner that benefits the practitioner and may not be in the client's best interest. In legal parlance undue influence involves the "exertion of improper influence and submission to the domination of the influencing party. . . . In such a case, the influencing party is said to have an unfair advantage over the other based, among other things, on real or apparent authority, knowledge of necessity or distress, or a fiduciary or confidential relationship" (Gifis 1991:508). The American Medical Association's *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatrists* (2009) specifically addresses the concept of undue influence: "The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him/her by the psychotherapeutic situation to influence the patient in any way not directly relevant to the treatment goals" (sec. 3, annotation 2).

In contrast to boundary violations, a boundary crossing occurs when a

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human service professional is involved in a dual relationship with a client or colleague in a manner that is not exploitative, manipulative, deceptive, or coercive. Boundary crossings are not inherently unethical; they often involve boundary bending as opposed to boundary breaking. In principle the consequences of boundary crossings may be harmful, salutary, or neutral (Gutheil and Gabbard 1993). Boundary crossings are harmful when the dual relationship has negative consequences for the practitioner's client or colleague and, potentially, the practitioner. For example, a professional who discloses to a client personal, intimate details about his own life, ostensibly to be helpful to the client, ultimately may confuse the client and compromise the client's mental health because of complicated transference issues produced by the practitioner's self-disclosure. An educator or internship supervisor in the human services who accepts a student's dinner invitation may inadvertently harm the student by confusing him about the nature of the relationship.

Alternatively, some boundary crossings may be helpful to clients and colleagues (Zur 2007). Some professionals argue that, handled judiciously, a practitioner's modest self-disclosure, or decision to accept an invitation to attend a client's graduation ceremony, may prove, in some special circumstances, to be therapeutically useful to a client (Anderson and Mandell 1989; Chapman 1997). A practitioner who coincidentally worships at the same church, mosque, or synagogue as one of his clients may help the client normalize the professional-client relationship. Yet other boundary crossings produce mixed results. A practitioner's self-disclosure about personal challenges may be both helpful and harmful to the same client—helpful in that the client feels more connected to the practitioner and harmful in that the self-disclosure undermines the client's confidence in the practitioner. The human service administrator who hires a former client initially may elevate the former client's self-esteem, but boundary problems will arise if the employee subsequently wants to resume his status as an active client in order to address some new issues that have emerged in his life.

Practitioners should also be aware of the conceptual distinction in the terms *impropriety* and *appearance of impropriety*. An impropriety occurs when a practitioner violates a client's boundaries or engages in inappropriate dual relationships in a manner that violates prevailing ethical standards. Conducting a sexual relationship with a client and borrowing money from a client are clear examples of impropriety. In contrast, an appearance of impropriety occurs when a practitioner engages in conduct that appears to be improper but in fact may not be. Nonetheless, even the appearance of impropriety may be ethically problematic and harmful.

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Let me illustrate this with a personal example. A number of years ago I had a leave of absence from my academic position and served as a senior policy adviser to the governor in my state. In that position I helped formulate public policy related to a number of human services issues. I worked directly with the governor when important issues arose, such as when relevant bills were pending in the state legislature. After several years I resigned that position to return to my academic duties; shortly thereafter the governor concluded his term in office. The new governor then appointed me to the state parole board, which entails conducting hearings for prison inmates eligible for parole. After I began serving in that position, the former governor—my former employer—was indicted and charged in criminal court with committing offenses while in office (among other issues, this complex case involved financial transactions between the governor, his political campaign staff, and building contractors and other parties who sought state contracts). The former governor was subsequently convicted and sentenced to prison. When he became eligible for parole and was scheduled to appear before me, I had to decide whether to participate in his hearing or recuse myself. I knew in my heart that I would be able to render a fair decision; the former governor was not a personal friend, and I had no knowledge of the events that led to his criminal court conviction. However, I also knew that I needed to be sensitive to the *appearance* of impropriety. I could not expect the general public to believe that I could be impartial, in light of my relationship with the man when he had been in office. No matter how certain I was of my ability to be fair and impartial, I had to concede that, at the very least, it would appear that I was involved in an inappropriate dual relationship. Because of the likely appearance of impropriety, I decided to recuse myself. Thus, although engaging in behaviors that only appear to be improper may not be unethical, human service practitioners should be sensitive to the effect that such appearances may have on their reputation and the integrity of their profession.

EMERGING BOUNDARY CHALLENGES: SOCIAL MEDIA AND ELECTRONIC COMMUNICATIONS

Some boundary issues in the human services have existed since the invention of the helping professions themselves. Examples include sexual attraction between clinician and client, practitioner self-disclosure, and the management of dual relationships in small communities. However, other boundary issues are of much more recent vintage, especially those involving practitioners'

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use of social media and various electronic communications and interventions. As I will explore more fully, the advent of Facebook, Twitter, email, cell and smartphones, videoconferencing, and web-based therapies has triggered a wide range of challenging boundary issues that did not exist when many contemporary practitioners concluded their formal education. Practitioners who use Facebook must decide whether to accept clients' requests for "friend" status. Similarly, practitioners must decide whether they are willing to exchange email and text messages with clients and, if so, under what circumstances; share their cell phone numbers with clients; offer clinical services by means of videoconferencing or other cybertherapy options, such as those that allow clients to represent themselves using graphical avatars rather than real-life images.

These novel electronic media have forced practitioners to think in entirely new and challenging ways about the nature of professional boundaries. Self-disclosure issues are no longer limited to practitioners' in-office sharing of information with clients about aspects of their personal lives. Practitioners' strategies for setting limits with regard to clients' access to them are no longer limited to office and landline telephone availability. Widespread use of email, text messaging, and cell phones has greatly expanded practitioners' availability, thus requiring them to think differently about boundary management. As Zur notes,

> The technological explosion toward the end of the 20th century, with its widespread use of cell phones, e-mails, and more recently, Instant Messaging (IM), chat rooms, video teleconferencing (VTC), text messaging, blogging, and photo-cell technology, has changed the way that billions of people communicate, make purchases, gather information, learn, meet, socialize, date, and form and sustain intimate relationships. Like global, national, and cultural boundaries, therapeutic boundaries are rapidly changing as a result. . . .
>
> Telehealth and online therapy practices challenge boundaries both around and within the therapeutic relationship. Telehealth or online therapy transcends the physical boundaries of the office as phone or Internet-based therapies take place in the elusive setting we often refer to as cyberspace. Nevertheless, telehealth is subject to exactly the same federal and state regulations, codes of ethics, and professional guidelines that define the fiduciary relationship in face-to-face and office-based therapy.
>
> (2007:133, 136)

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A TYPOLOGY OF BOUNDARY ISSUES AND DUAL RELATIONSHIPS: A SYNOPSIS

Given the great range of both long-standing and novel boundary issues in the human services, practitioners need a conceptual framework to help them identify and manage dual relationships they encounter. What follows is a brief overview of a typology of boundary issues; I based it on several data sources: insurance industry statistics summarizing malpractice and negligence claims; empirical surveys of human service professionals about boundary issues; legal literature and court opinions in litigation involving boundaries; and my experience as chair of a statewide ethics committee and expert witness in a large number of legal cases throughout the U.S. involving boundary issues. Following this brief overview I will explore the elements of this typology in greater depth.

Boundary issues in the human services fall into five conceptual categories: intimate relationships, pursuit of personal benefit, how professionals respond to their own emotional needs, altruistic gestures, and responses to unanticipated circumstances.

INTIMATE RELATIONSHIPS

Many dual relationships in the human services involve some form of intimacy. Typically, these relationships entail a sexual relationship or physical contact, although they may also entail other, more subtle, intimate gestures, such as gift giving, friendship, and affectionate communication.

Sexual relationships. A distressingly significant portion of intimate dual relationships involves sexual contact (Akamatsu 1988; Bouhoutsos 1985; Coleman and Schaefer 1986; Celenza 2007; Committee on Women 1989; Feldman-Summers and Jones 1984; Gabbard 1989; Gechtman 1989; Gutheil and Brodsky 2008; Pope and Bouhoutsos 1986; Reamer 1992; Sell, Gottlieb, and Schoenfeld 1986; Strom-Gottfried 1999; Syme 2003). Human service professionals agree that sexual relationships between clinicians and current clients are inappropriate but are not so unanimous regarding sexual relationships with former clients.

Professionals must also be aware of other potentially problematic sexual relationships that may involve a client indirectly. For example, current ethical standards in most human service professions prohibit sexual relationships

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between practitioners and a client's relatives or other individuals with whom a client maintains a close personal relationship. Typical is the NASW *Code of Ethics* (2008) standard on this issue:

> Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers—not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.
>
> (standard 1.09[b])

Other potentially problematic sexual relationships can occur between educators, supervisors, or trainers in the human service professions and their students, supervisees, or trainees.

Physical contact. Not all physical contact between a practitioner and a client is explicitly sexual in nature. Physical contact in a number of circumstances may be asexual and appropriate—for example, a brief hug at the termination of long-term treatment or placing an arm around a client in a residential program who just received bad family news and is distraught. Such brief, limited physical contact may not be harmful; many clients would find such physical contact comforting and therapeutic, although other clients may be upset by it (perhaps because of their personal trauma history or their cultural or ethnic norms related to touching).

Some forms of physical contact have greater potential for psychological harm. In these circumstances physical touch may exacerbate a client's transference in destructive ways and may suggest that the practitioner is interested in more than a professional relationship. For example, a clinician provided counseling to a twenty-eight-year-old woman who had been sexually abused as a child. As an adult the client sought counseling to help her understand the effects of the early victimization, especially those pertaining to her intimate relationships. As part of the therapy the practitioner, aiming to comfort the client, would occasionally dim the office lights, turn on soft music, and sit on the floor while cradling and talking with the client. The client was thus

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retraumatized because this physical contact with the clinician exacerbated the client's confusion about intimacy and boundaries with important people in her life.

The NASW *Code of Ethics* (2008) is one of the few professional ethics codes that includes a standard pertaining specifically to the concept of physical touch: "Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact" (standard 1.09[d]).

Counseling a former lover. Providing clinical services to someone with whom a practitioner was once intimately, romantically, or sexually involved also constitutes a dual relationship. The relationship history is likely to make it difficult for the practitioner and the client to interact with each other solely as professional and client; inevitably, the dynamics of the prior relationship will influence the professional-client relationship—how the parties view and respond to each other—perhaps in ways that are detrimental to the client's best interests. According to the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (2010), "Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies" (standard 10.07).

Intimate gestures and friendships. Boundary issues can also emerge when practitioners and clients engage in other intimate gestures, such as gift giving and expressions of friendship (including sending affectionate notes, for example, on the practitioner's personal stationery). It is not unusual for a client to give a clinician or case manager a modest gift. Certainly, in many instances a client's gift represents nothing more than an appreciative gesture. In some instances, however, a client's gift may carry great meaning. For example, the gift may reflect the client's fantasies about a friendship or more intimate relationship with the practitioner. Thus it behooves the professional to carefully consider the meaning of a client's gift and establish prudent guidelines governing the acceptance of gifts. Many social service agencies do not permit staff members to accept gifts because of the potential conflict of interest or appearance of impropriety, or they permit gifts of only modest value. Some agencies permit staff to accept gifts only with the understanding—which is conveyed to clients—that the gifts represent a contribution to the agency, not to the individual professional.

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The human service professions agree that friendships with current clients constitute inappropriate dual relationships. There is less clarity, however, about friendships between professionals and *former* clients. Although professionals generally understand the risk involved in befriending a former client—the possibility of confused boundaries—some professionals argue that friendships with former clients are not inherently unethical and reflect a more egalitarian, nonhierarchical approach to practice. These professionals typically claim that emotionally mature practitioners and former clients are quite capable of entering into new kinds of relationships after termination of the professional-client relationship and that such new relationships often are, in fact, evidence of the former client's substantial therapeutic progress. Later I will explore this complex debate more thoroughly.

PERSONAL BENEFIT

Beyond these various manifestations of intimacy, human service professionals can become involved in dual relationships that produce other forms of personal benefit, including monetary gain, goods, services, or useful information.

Monetary gain. In some situations a practitioner stands to benefit financially as a result of a dual relationship (Bonosky 1995). In one case, a counselor's former client decided to change careers and become a therapist. After completing graduate school, the client contacted her former therapist and asked to become the former therapist's supervisee (supervision was required for a state license). The counselor was tempted to take on the supervision for a fee, in part because he enjoyed their relationship and in part because of the financial benefit. But the counselor also recognized that the shift from the counselor-client relationship to a collegial relationship would introduce a number of boundary issues.

In another case, a client named a counselor in his will. After the client's death and probate of the will, the client's family accused the counselor of undue influence (the family alleged that the counselor had encouraged the client to bequeath a portion of the estate to the counselor).

Goods and services. On occasion, human service professionals receive goods or services, rather than money, as payment for their professional services. This occurs especially in some rural communities, where barter is an accepted form of payment. In one case, a rural practitioner's client lost his mental health insurance coverage yet still needed counseling services. The

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client, a house painter, offered to paint the counselor's home in exchange for clinical services. The counselor decided not to enter into the barter arrangement; after consulting with colleagues, she realized that the client's interests could be undermined should some problem emerge with the paint job that would require some remedy or negotiation (for example, if the paint job proved to be inferior in some way). In another case, a social worker received several paintings from a client, an artist, as payment for services rendered. This social worker reasoned that accepting goods of this sort was not likely to undermine the clinical relationship, whereas accepting a service might.

The NASW *Code of Ethics* is an example of a prominent code that includes a specific standard on barter. The NASW Code of Ethics Revision Committee, which I chaired, struggled to decide whether to prohibit or merely discourage all forms of barter. On the one hand, bartering entails potential conflicts of interest; on the other hand, bartering is an accepted practice in some communities. Ultimately, the committee decided to strongly discourage barter because of the risks involved while recognizing that barter is not inherently unethical. Further, the code establishes strict standards for the use of barter by social workers:

> 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.
>
> (standard 1.13[b]; emphasis added)

The ethics codes of the American Counseling Association (2005; standard A.10.d) and the American Association for Marriage and Family Therapy (AAMFT) (2001; standard 7.5) include somewhat similar standards.

Useful information. A human service professional occasionally has an opportunity to benefit from a client's unique knowledge. A counselor with a

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complex health problem may be tempted to consult her client who is a physician and who happens to specialize in the area relevant to the counselor's chronic illness. A psychologist who is interested in adopting a child, and whose client is an obstetrics and gynecology nurse who works in a teen pregnancy clinic, may be tempted to talk to his client about adoption opportunities through the client's clinic. An agency administrator who is an active stock-market investor may be tempted to consult a client who happens to be a stockbroker. A social worker with automobile problems may be tempted to consult a client who happens to be a mechanic. These situations entail the clear potential for an inappropriate dual relationship because the professional uses a portion of the client's therapeutic session for the practitioner's own purposes, and the practitioner's judgment and services may be shaped and influenced by access to a client's specialized knowledge. The client's transference also may be adversely affected. Conversely, relatively brief, casual, and nonexploitative conversation with a client concerning a topic on which the client is an expert may empower the client, facilitate therapeutic progress, and challenge the traditionally hierarchical relationship between professional and client.

EMOTIONAL AND DEPENDENCY NEEDS

A number of boundary issues arise from practitioners' efforts to address their own emotional needs. Many of these issues are subtle, although some are more glaring and egregious. Among the more egregious are the following examples on which I have consulted:

- The administrator of a state child welfare agency that serves abused and neglected children was having difficulty coping with his failing marriage. He was feeling isolated and depressed. The administrator was arrested based on evidence that he had developed a sexual relationship with a sixteen-year-old boy who was in the department's custody and that he used illegal drugs with the boy.
- A psychologist in a private psychiatric hospital provided counseling to a resident who was diagnosed with paranoid schizophrenia. The psychologist, who was religiously observant, began to read biblical passages to his client in the context of counseling sessions. The client was not religiously observant and complained to other hospital staff about the psychologist's conduct.

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- A psychiatric nurse in private practice provided psychotherapy services to a forty-two-year-old woman who had been sexually abused as a child. During the course of their relationship, the nurse invited the client to her home for several candlelight dinners, went on a camping trip with the client, gave the client several expensive gifts, and wrote the client several very affectionately worded notes on personal stationery.
- A social worker in a public child welfare agency was responsible for licensing foster homes. The social worker, who was recently divorced, became friendly with a couple who had applied to be foster parents. The social worker also became involved in the foster parents' church. The social worker, who approved the couple's application and was responsible for monitoring foster home placements in their home, moved with her son into a trailer on the foster parents' large farm.

Other boundary issues are more subtle. Examples include professionals whose clients invite them to attend important life-cycle events (such as a wedding or graduation, or a key religious ceremony), professionals who conduct home visits as a meal is being served and whose clients invite them to sit down to eat, and professionals who themselves are in recovery and encounter a client at an Alcoholics or a Narcotics Anonymous meeting. Professionals sometimes disagree about the most appropriate way to handle such boundary issues. For example, some professionals are adamantly opposed to attending a client's life-cycle event because of potential boundary problems (for example, the possibility that the client might interpret the gesture as a sign of the practitioner's interest in a social relationship or friendship); others, however, believe that attending such events can be ethically appropriate and, in fact, therapeutically helpful, so long as the clinical dynamics are handled skillfully. Further, some professionals believe that practitioners in recovery should never attend or participate in AA or NA meetings that a client might attend, because of the difficulty that clients may have reconciling the practitioner's professional role and personal life. Others, however, argue that recovering practitioners have a right to meet their own needs and can serve as compelling role models to clients in recovery.

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ALTRUISM

Some boundary issues and dual relationships arise from professionals' genuine efforts to be helpful. Unlike a professional's involvement in a sexual relationship, or a dual relationship that is intentionally self-serving, altruistic gestures are benevolently motivated. Although these dual relationships are not always inherently unethical, they do require skillful handling, as in the following examples:

- A psychiatrist in private practice was contacted by an acquaintance—not a close friend—who was in the midst of a marital crisis. The acquaintance told the psychiatrist that she and her husband "really trusted" the psychiatrist and wanted the psychiatrist's professional help. The psychiatrist agreed to see the couple professionally but later realized that being objective was difficult.
- A social worker in a family service agency provided casework services to a client who had a substance abuse problem. The client asked the social worker if she would like to purchase wrapping paper that the client's daughter was selling as a school fund-raiser.
- A woman who had been diagnosed with agoraphobia sent an email message to a psychologist asking whether the psychologist would be willing to provide Internet counseling for a period of time as a prelude to a possible office-based visit.
- A counselor in a community mental health center provided psychotherapy services for many years to a young man with a history of clinical depression. The client asked the counselor to say a few words during the ceremony at the client's upcoming wedding.
- A psychiatric nurse in a small rural community provided counseling to a ten-year-old boy who struggled with self-esteem issues. In his spare time the nurse coached the community's only youth basketball team, which played in a regional league. The nurse believed that the boy would benefit from joining the basketball team (for example, by developing social skills and new relationships) and encouraged the boy to join the team.

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UNAVOIDABLE AND UNANTICIPATED CIRCUMSTANCES

The final category of boundary issues involves situations that behavioral health professionals do not anticipate and over which they have little or no initial control. The challenge for the professional in these circumstances is to manage the boundary issues in ways that minimize any harm to a client or colleague. Consider the following examples:

- A social worker in private practice attended a family holiday gathering. The social worker's sister introduced him to her new boyfriend, who is a former client of the social worker.
- The client of a psychotherapist in a rural community was a grade school teacher. Because of an unexpected administrative decision, the client became the classroom teacher of the psychotherapist's child.
- A mental health counselor discovered that she and her client had Facebook friends in common.
- A psychologist at a community mental health center joined a local fitness club. During a visit to the club the psychologist learned that an active client also was a member.

MANAGING BOUNDARIES AND DUAL RELATIONSHIPS

As I have discussed, not all dual relationships entail unethical circumstances, although some do. Some dual relationships are clearly self-serving and exploitative. Others, however, are ambiguous and contain features about which reasonable, thoughtful human service professionals may disagree.

As I will discuss more fully later, to protect clients and minimize the potential for harm—and to minimize the possibility of ethics complaints and lawsuits that allege misconduct or professional negligence—human service professionals should establish clear risk-management criteria and procedures. These criteria and procedures increase the chances that a practitioner will protect clients and would be determinative should a disgruntled client or third party allege malpractice. A sound risk-management protocol to deal with boundary issues should contain six major elements. Human service professionals should

- Be vigilant in their efforts to recognize potential or actual conflicts of interest in their relationships with clients and colleagues. Professionals should

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be cognizant of red flags that may signal a boundary problem. For example, clinical practitioners should be wary when they find themselves attracted to a particular client, going out of their way to extend a client's counseling sessions (facilitated by scheduling the favored client at the end of the day), acting impulsively in relation to the client, allowing the client to accumulate a large unpaid bill, and/or disclosing personal information to the client. Professionals should be sure to inform the client and appropriate colleagues when they encounter complex boundary issues, including actual or potential conflicts of interest, and explore reasonable remedies.

- Consult colleagues and supervisors, relevant professional literature on boundary and ethical issues, relevant statutes and regulations, agency policies, and ethical standards (codes of ethics) in order to identify pertinent boundary issues and constructive options. Professionals should take special care in high-risk circumstances. For example, a professional who attempts to make a decision about whether to enter into a friendship with a former client should consider prevailing ethical standards, including those pertaining to the amount of time that has passed since the termination of the professional-client relationship; the extent to which the former client is mentally competent and emotionally stable; the issues addressed in professional-client relationship; the length of the professional-client relationship; the circumstances surrounding the termination of the professional-client relationship; and the extent to which harm to the former client or others as a result of the new relationship is foreseeable (Reamer 2006a–b).
- Design a plan of action that addresses the boundary issues and protects clients to the greatest extent possible. In some circumstances protecting the client's interests may require termination of the professional relationship with proper referral of the client.
- Document all discussions, consultation, supervision, and other steps taken to address boundary issues.
- Develop a strategy for monitoring the implementation of the action plan—for example, by periodically conducting assessments with relevant parties (clients, colleagues, supervisors, lawyers) to determine whether the strategy minimized or eliminated the boundary problems.

These steps can help professionals protect clients and prevent ethics complaints and lawsuits alleging negligent conduct. In all the human service professions, state licensing or regulatory boards receive ethics complaints. These publicly sponsored bodies—which are established under the authority

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of state licensing statutes—are charged with reviewing, investigating, and, when warranted, adjudicating ethics complaints filed against professionals. When a licensing and regulatory board concludes that a practitioner has violated a client's boundaries or engaged in an unethical dual relationship, it may impose various sanctions and requirements for corrective action, including censure; mandated continuing education, supervision, and consultation; probation; and license suspension or revocation.

Some national professional associations also have a mechanism for reviewing and, when necessary, adjudicating ethics complaints against members. For example, the National Association of Social Workers permits individuals to file ethics complaints against its members. Based on the concept of peer review, each state chapter has an ethics committee whose function is to process ethics complaints in collaboration with the National Ethics Committee. If the complaint is accepted by the national intake committee, it decides whether to offer mediation as an option or to refer the matter for formal adjudication. As a matter of policy, cases involving allegations of sexual harassment, relationships, and physical contact are not eligible for mediation. Cases involving allegations of other boundary-related issues may be eligible for mediation.

If the case is referred for adjudication, the chapter ethics committee conducts a formal hearing during which the complainant (the person filing the complaint), the respondent (the person against whom the complaint is filed), and witnesses have the opportunity to testify. After hearing all parties and discussing the testimony, the ethics committee summarizes its findings and presents recommendations. NASW members who are found in violation of ethical standards concerning boundaries and dual relationships may be sanctioned or required to engage in some form of corrective action. These measures may include suspension or expulsion from NASW, censure, or a requirement to obtain continuing education, consultation, or supervision. In some instances, the findings may be publicized through local and national NASW publications. Other professional associations have a similar protocol, although specific procedures vary.

In addition, individuals who believe they have been harmed by an unethical dual relationship with a practitioner may file malpractice claims and negligence lawsuits (Austin, Moline, and Williams 1990; Bernstein and Hartsell 2008 Madden 1998; Reamer 2003a). Lawsuits and liability claims that allege malpractice are civil suits, in contrast to criminal proceedings. Ordinarily, civil suits are based on tort or contract law, with plaintiffs (the

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individuals bringing the suit) seeking some sort of compensation for injuries they claim to have incurred. These injuries may be economic (for example, lost wages or medical expenses that resulted when a client became sexually involved with her therapist and was traumatized and unable to work), physical (for instance, as a result of a sexual assault on a client by a practitioner), or emotional (for example, depression that may result from a practitioner's sexual contact with a client).

As in criminal trials, defendants in civil lawsuits are presumed to be innocent until proved otherwise. In ordinary civil suits defendants will be found liable for their actions based on the standard of preponderance of the evidence, as opposed to the stricter standard of proof beyond a reasonable doubt used in criminal trials. In some civil cases—for example, those involving contract disputes, as opposed to boundary issues—the court may expect clear and convincing evidence, a standard of proof that is greater than preponderance of the evidence but less than for beyond a reasonable doubt.

In general, malpractice occurs when evidence exists that (1) at the time of the alleged malpractice a legal duty existed between the practitioner and the client (for example, a counselor has a duty to maintain proper boundaries with clients); (2) the practitioner was derelict in that duty, either through an action that occurred or through an omission (the practitioner engaged in a sexual relationship with a client); (3) the client suffered some harm or injury (the emotional harm associated with the boundary violation); and (4) the harm or injury was directly and proximately caused by the counselor's dereliction of duty (the unethical sexual relationship was the direct and proximate cause of the emotional harm suffered by the client).

Whether a practitioner violated his or her duty is based on current standards of care in the profession. The standard of care is defined as the way an ordinary, reasonable, and prudent professional would act under the same or similar circumstances (Austin, Moline, and Williams 1990; Bernstein and Hartsell 2004; Madden 1998; Reamer 2003a). Some standards of care related to boundaries and dual relationships are clear; others are not. For example, an ordinary, reasonable, and prudent professional clearly would not engage in a sexual relationship with a clinical client or enter into a business relationship with a client. In contrast, professionals disagree about whether barter between a professional and a client should be prohibited in all instances, whether practitioners should decline all gifts and social invitations from clients, and whether friendship between a practitioner and a former client should always be prohibited. As we will see shortly, professionals face

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the greatest challenges when they encounter boundary and dual relationship issues for which no clear standards of care exist.

SOUND DECISION MAKING

The best strategy for protecting clients and preventing ethics complaints and lawsuits—especially when human service professionals face complex boundary issues for which no clear standards of care exist—is to engage in a systematic, deliberate, and comprehensive series of decision-making steps. Ethicists generally agree that approaching ethical decisions in this fashion is important to ensure that all aspects of an ethical dilemma are addressed. In my experience it is helpful for human service professionals to follow specific steps when attempting to make difficult decisions related to boundaries and dual relationships (Reamer 2006c, 2009a–d).

1. *Identify the boundary and dual relationship issues, including the professional duties and obligations that conflict.* Complex boundary and dual relationship issues often entail conflicts among, or ambiguities related to, professional duties and obligations. For example, practitioners who are in recovery from alcohol abuse may face difficult decisions when they unexpectedly encounter a client, who is also in recovery, at an Alcoholics Anonymous meeting. Practitioners in recovery need to handle conflicts between their duty to protect clients from harm and their right to address their own recovery issues. Whether practitioners decide to participate in or leave AA meetings when a client is present depends on their views about these conflicting duties and obligations. Carefully identifying the issues and alternative ways of handling them increases the chances that the practitioner will analyze the situation thoroughly and thereby enhance protection of clients and themselves.

2. *Identify the individuals, groups, and organizations that the ethical decision is likely to affect.* In each instance human service professionals should do their best to identify the parties that their decision may affect and the ways in which it is likely to affect them. A counselor in recovery who is trying to decide how to handle her and her client's coincidental attendance at the same AA meetings needs to think about the potential effect on the client primarily but also on the client's family and close acquaintances, the counselor herself, the counselor's employer, the counselor's malpractice and liability insurer, and the counselor's profession and professional colleagues.

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Clearly, the counselor's participation in the AA meeting could affect the client and these other parties.

3. *Tentatively identify all viable courses of action and the participants involved in each, along with the potential benefits and risks for each.* Human service professionals should think through all realistic options and then engage in the conceptual equivalent of a cost-benefit analysis. In the AA example, in principle the practitioner faces several possibilities upon seeing a client at an AA meeting: attend the meeting and speak to the group about her own recovery issues; attend the meeting without speaking about her own recovery issues; and leave the meeting and explore an alternative meeting site. In addition, the practitioner would need to decide what to say to the client about their unanticipated, chance encounter and its implications for their future clinical relationship. The first option offers several potential benefits. Attending the meeting and speaking would provide the practitioner with an opportunity to address her own recovery issues. She would also serve as a role model for her client, which may enhance the client's recovery efforts. In addition, the practitioner may have greater credibility in the client's eyes because of the practitioner's personal experience with recovery issues.

However, risks are involved as well. The dual relationship may confuse the client, who may have some difficulty distinguishing between the practitioner's role as a professional counselor and as another recovering alcoholic who needs the client's support and understanding. This confusion could undermine the client's recovery efforts. In principle the practitioner's credibility may suffer if the client concludes that a counselor who is struggling with her own recovery issues is not in a position to counsel others who are in recovery. In addition, the client's presence at an AA meeting could undermine the practitioner's recovery; the practitioner may feel self-conscious and constrained by the client's presence and may be reluctant to address personal issues that she would address in the client's absence. Thus the practitioner's earnest efforts to protect her client could interfere with the practitioner's own therapeutic progress.

The second option—attending the AA meeting without speaking—also entails potential costs and benefits. The practitioner's presence could be reassuring to the client and may enhance the practitioner's credibility. Participating in the group discussion, even though she chooses not to speak at this particular meeting, may enhance the practitioner's own recovery efforts. At the same time, however, this course entails potential costs. As with the first option, the client may be confused about the practitioner's role in his life,

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and the practitioner may feel constrained in her efforts to address her own recovery issues. The practitioner's credibility may decline in the client's opinion if the client concludes that a counselor who is struggling with her own recovery issues is in no position to guide the client effectively.

The third option—leaving the meeting and perhaps finding an alternative twelve-step meeting—would help the practitioner and client avoid a potentially problematic dual relationship. At the same time this would remove the possibility of any benefits that could result from the practitioner's and client's simultaneous attendance at the AA meeting and efforts to address their respective recovery issues.

4. *Thoroughly examine the reasons in favor of and opposed to each course of action, considering relevant ethical theories, principles, and guidelines.*

Analysis and resolution of practical ethical dilemmas. As I noted earlier, since the mid-1970s interest in professional ethics has grown dramatically, particularly in relation to boundary and dual relationship issues. One feature of this development, especially since the 1980s, has been the deliberate exploration of the relevance of moral philosophy and ethical theory to the analysis and resolution of practical ethical dilemmas that human service professionals face; similar developments occurred in nearly all major professions, such as medicine, nursing, business, journalism, law, engineering, and the military. Currently, most professional education programs acquaint students with core ethics concepts, theories, and conceptual frameworks to enhance their management of ethical challenges.

Briefly, pertinent ethical theories and principles concern what moral philosophers call *metaethics* and *normative ethics.* Metaethics concerns the meaning of ethical terms or language and the derivation of ethical principles and guidelines. Typical metaethical questions concern the meaning of the terms *right* and *wrong* and *good* and *bad.* What criteria should we use to judge whether a social worker, counselor, or psychologist has engaged in unethical conduct by violating professional boundaries and engaging in an inappropriate dual relationship? How should we go about formulating ethical principles to guide individuals who struggle with moral choices related to boundary issues and dual relationships?

In contrast to metaethics, which is relatively abstract, normative ethics tends to be of particular interest to human service professionals because of its immediate relevance to practice. Normative ethics consists of attempts to apply ethical theories and principles to actual ethical dilemmas. Such guidance is especially useful when professionals face conflicts among duties

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they are ordinarily inclined to perform—what the philosopher W. D. Ross (1930) refers to as the challenge to identify one's principal duty (or *actual* duty, to use Ross's term) from among competing or conflicting prima facie duties (that is, duties that should be performed at first view).

Reconciling conflicting prima facie duties is a common challenge with respect to professional boundaries. In the case of the AA meeting, for example, the practitioner faces a choice involving conflicting prima facie duties to her client, herself, and her profession. Deciding on one's actual duty can be daunting.

Theories of normative ethics can be useful in the analysis of boundary and dual relationship issues. Philosophers generally group theories of normative ethics under two main headings. Deontological theories (from the Greek, *deontos*, 'of the obligatory') are those that claim that certain actions are inherently right or wrong, or good or bad, without regard for their consequences. Thus a deontologist—the best known is Immanuel Kant, the eighteenth-century German philosopher—might argue that engaging in a sexual relationship with a client is inherently wrong and that practitioners should never exploit clients in this way. The same might be said about investing in a client's business, socializing with a client, or accepting expensive gifts from a client. For deontologists moral rules, rights, and principles are sacred and inviolable. The ends do not justify the means, particularly if the means require violating some important moral rule, right, principle, or the law (Cahn and Markie 2008; Frankena 1973).

The second major group of theories, teleological theories (from the Greek *teleios*, 'brought to its end or purpose'), takes a different approach to ethical choices. From this point of view the rightness of any action is determined by the goodness of its consequences. For teleologists (also known among moral philosophers as consequentialists), making ethical choices without weighing potential consequences is naive. To do otherwise is to engage in what the philosopher J. J. C. Smart (1971) refers to as "rule worship." Hence from this consequentialist perspective, the responsible decision-making strategy entails an attempt to anticipate the outcomes of various courses of action and to weigh their relative benefits and costs. For example, a practitioner who is contemplating disclosing personal information to a client, accepting a client's gift or social invitation, or attending the same AA meeting that a client attends would identify the potential and likely outcomes of these choices and speculate about the potential benefits and costs for all relevant parties (the client, practitioner, practitioner's employer, and relevant third parties).

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The two major teleological schools of thought are known by moral philosophers as *egoism* and *utilitarianism*. Egoism typically has no place in the human services; according to this self-serving perspective, practitioners faced with conflicting prima facie duties should act in ways that maximize their personal self-interest. Thus a practitioner contemplating a sexual relationship with a client would be concerned primarily, and perhaps exclusively, with his own potential satisfaction and contentment. Although few human service practitioners think along these egoistic lines, some do. When I have testified as an expert witness in court and licensing board cases brought against practitioners for alleged boundary violations, I have met a number of practitioners who seemed primarily concerned about their own emotional satisfaction and, narcissistically and egoistically, entered into self-serving dual relationships that harmed clients. As I will discuss more fully, many of these practitioners struggled with personal issues that led to some form of impaired judgment. These personal challenges often involve troubled marriages or primary relationships, career frustration, and a wide range of mental health issues (such as depression or addiction).

In contrast to egoism, the school of thought known as utilitarianism holds that an action is morally right if it promotes the maximum good. Historically, utilitarianism has been the most popular teleological theory among human service professionals and has, at least implicitly, served as justification for many decisions that practitioners make regarding boundaries and dual relationships. According to the classic form of utilitarianism—as generally formulated by the English philosophers Jeremy Bentham in the eighteenth century and John Stuart Mill in the nineteenth century—when faced with conflicting moral duties, one should perform the action that is likely to produce the greatest good. In principle, then, a practitioner should engage in a calculus to determine which set of consequences will produce the greatest good. (An alternative view is that practitioners should aim to minimize harm rather than maximize good. Donagan [1977] refers to this as "negative utilitarianism," and Popper [1966] refers to it as the "minimization of suffering.") Thus a counselor might argue on utilitarian grounds that the harm that may result from a sexual relationship with a former client—no matter how voluntary, satisfying, and consensual—outweighs any likely benefits. That is, the emotional harm that could result for the client—and perhaps the counselor and other relevant parties—would be more substantial than any pleasure (emotional and physical) that would result from the sexual relationship.

Some philosophers argue that it is important and helpful to distinguish

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between two subtypes of utilitarianism: act and rule utilitarianism (Gorovitz 1971). According to act utilitarianism, the goodness of the consequences in *that individual case* (or act) determines the rightness of an action. One does not need to look beyond the implications of this one instance. In contrast rule utilitarianism takes into account the long-run consequences when one treats the case as a precedent. Thus an act utilitarian might justify a sexual relationship with a former client if there is evidence that this would result in the greatest good for the parties involved in this particular set of circumstances. A rule utilitarian, however, might argue that the precedent established by this boundary violation would generate more harm than good if *all* human service professionals used this cost-benefit reasoning, regardless of the benefits produced in this one case. That is, a rule utilitarian might argue that the precedent would undermine clients' and the public's trust in human service professionals, particularly regarding professionals' determination to protect clients from harm and exploitation, thus limiting the human services' general effectiveness as a profession. The distinction between act and rule utilitarianism is similarly useful with regard to other boundary issues, for example, whether it is morally acceptable to disclose personal information to a client, accept a client's gift, perform favors for a client, attend an AA meeting with a client, or barter with a client for professional services. What may seem ethically justifiable in any one case (act utilitarianism) may seem unjustifiable if one treats that one case as a precedent that one then generalizes to all human service professionals who are in comparable circumstances.

Codes of ethics and legal principles. Other tools to help human service professionals examine the reasons in favor of and opposed to a course of action are professional codes of ethics and pertinent legal principles. Ethical standards have matured greatly in all the human service professions. Earlier versions were much more superficial and abstract than they are today. For example, the first code of ethics ratified by the National Association of Social Workers, in 1960, was one page long and consisted of only fourteen broadly worded proclamations concerning, for example, every social worker's duty to give precedence to professional responsibility over personal interests; to respect the privacy of clients; to give appropriate professional service in public emergencies; and to contribute knowledge, skills, and support to human welfare programs. In contrast, the current version of the NASW *Code of Ethics* contains 155 specific ethical standards (along with more abstract ethical principles, core values, and a mission statement for the profession) to

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guide social workers' conduct and provide a basis for adjudication of ethics complaints filed against NASW members. These guidelines are used as well by many state licensing boards that have formally adopted the NASW code standards, in whole or in part. This trend, toward more detailed and specific ethical standards, has occurred in all major human service professions, reflecting the dramatic growth of knowledge related to professional ethics.

The codes of ethics of the various human service professions (especially counseling, marriage and family therapy, psychiatry, psychology, social work) include a wide range of standards related to boundary issues and dual relationships. The number of standards devoted to boundary issues and dual relationships has increased significantly in recent code revisions. Although the content and substantive issues addressed by the various codes overlap somewhat, note that they have some significant differences, which reflect the professions' diverse norms and ideological perspectives. I will draw on these various standards throughout this discussion (see the appendix for excerpts from relevant codes of ethics pertaining to boundaries, dual relationships, and conflicts of interest).

In addition to consulting relevant codes of ethics, human service professionals facing difficult ethical decisions should carefully consider relevant legal principles, including statutes (laws enacted by state legislatures and Congress), legal regulations (regulations established by public agencies that have the force of law), and case law (legal precedents established by courts of law). Although ethical decisions should not necessarily be dictated by prevailing statutory, regulatory, and case law, practitioners should always take legal guidelines and requirements into account. In some instances the law may reinforce practitioners' ethical instincts, such as when a state law stipulates that sexual contact with a former client is a felony punishable by imprisonment and/or a monetary fine. In fact, several states have enacted such a law.

Practice theory and principles from the literature of the human service professions. Practitioners should also consider the relevance of pertinent practice theory and principles. For example, if a therapist is struggling to decide whether to have posttermination social contact with a client who has been diagnosed with borderline personality disorder, the therapist should pay close attention to practice theory related to this clinical phenomenon. In light of what we know about borderline personality disorder, the therapist may want to avoid adding boundary-related complications to this client's life. Similarly, a counselor who is considering establishing a sexual relationship with

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a former client who has a history of sexual abuse should pay close attention to practice-based knowledge about posttraumatic stress disorder. And a community mental center administrator who is considering hiring former clients as employees should draw on available knowledge about relapse prevention and risks before making a decision about this unique boundary issue.

Values (including religious, cultural, and ethnic values and political ideology), particularly those that conflict with one's own. Human service professionals sometimes want to share their values with clients. Further, practitioners sometimes face conflicts between their personal values and their professional obligations. A practitioner may have very strong religious beliefs that, in her judgment, are relevant to a client's circumstances (for instance, when a client is struggling with moral issues related to an unplanned pregnancy or a marital affair); a practitioner who shares these religious beliefs with a client, or who invites a client to attend a church-sponsored event, would produce complex boundary issues. Boundary issues are especially complex when clients' values conflict with the practitioner's values (for example, related to abortion or engaging in tax or insurance fraud).

A similar challenge may arise when a politically active professional is tempted to organize clients to engage in some form of social lobbying or protest. Supporting one's own political agenda—by recruiting clients to support one's political agenda—may conflict with the ethical prescription to avoid inappropriate dual relationships.

5. *Consult with colleagues and appropriate experts (such as agency staff, supervisors, agency administrators, ethics experts, and attorneys).* Ordinarily, human service professionals should not make complex ethical decisions alone. The quality of practitioners' judgments about the management of complicated boundary issues can be greatly enhanced by conferring with thoughtful, principled colleagues. This is not to suggest that ethical decisions are always group decisions. Sometimes they are, but in many instances individual practitioners ultimately make the decision once they have had an opportunity to consult with colleagues, supervisors, administrators, and other experts.

Typically, practitioners should consider consulting with colleagues who are involved in similar work and who are likely to understand the issues. As the NASW *Code of Ethics* (2008) states: "Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interest of clients" (standard 2.05[a]), and "social workers should keep themselves informed about colleagues' areas of expertise and competencies. Social

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workers should seek consultation only from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation" (standard 2.05[b]). Sometimes the consultation may be obtained informally, in the form of casual and spontaneous conversation with colleagues, and sometimes, particularly in agency settings (such as community mental health centers, family service agencies, schools, psychiatric hospitals, nursing homes, and public child welfare departments), through more formal means, as with institutional ethics committees (Amdur and Bankert 2010; Hester 2007; Post, Blustein, and Dubler 2006; Reamer 1987, 1995b).

The concept of institutional ethics committees emerged most prominently in 1976, when the New Jersey Supreme Court ruled that Karen Anne Quinlan's family and physicians should consult an ethics committee in deciding whether to remove her from life-support technology (a number of hospitals have had something resembling ethics committees since the 1920s). The court based its ruling in part on an important article that appeared in the *Baylor Law Review* in 1975, in which a pediatrician advocated the use of an ethics committee when health-care professionals face difficult ethical choices (Teel 1975).

Ethics committees, which can include representatives from various disciplines, often provide case consultation in addition to education and training (Amdur and Bankert 2010; Cranford and Doudera 1984). Many agency-based ethics committees provide nonbinding ethics consultation and can offer an opportunity for practitioners who encounter complex boundary issues to think through case-specific issues with colleagues who have ethics expertise. Although ethics committees are not always able to provide definitive options about the complex issues that are frequently brought to their attention (nor should they be expected to), they can provide a valuable forum for thorough and critical analyses of difficult ethical dilemmas related to boundaries and dual relationships.

Obtaining sound consultation is important for two reasons. The first is that experienced and thoughtful consultants may offer useful insights concerning complicated boundary issues and may raise important questions that the human service professional had not considered. The expression "two heads are better than one" may seem trite, but it is often true.

The second reason is that such consultation may help practitioners protect themselves if they are sued or have complaints filed against them because of the decisions they make. That a practitioner sought consultation demonstrates that the practitioner approached the decision carefully and

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prudently, and made a good faith effort to make a responsible decision and adhere to prevailing professional standards; this can help if someone alleges that the practitioner made an inappropriate decision hastily and carelessly.

6. *Make the decision and document the decision-making process.* Once the practitioner has carefully considered the various boundary issues, including the values and duties that may conflict; identified the individuals, groups, and organizations that are likely to be affected by the decision; tentatively identified all potential courses of action and the participants involved in each, along with any benefits and risks for each; thoroughly examined the reasons in favor of and opposed to each course of action (considering relevant ethical theories, principles, and guidelines; codes of ethics and legal guidelines; human service practice theories and principles; and personal values); and consulted with colleagues and appropriate experts, it is time to make a decision. In some instances the decision will seem clear. Going through the decision-making process will have clarified and illuminated the issues so that the practitioner's ethical obligation seems unambiguous.

In other instances, however, practitioners may still feel somewhat uncertain about their ethical obligations related to the proper management of boundaries. These are the hard cases and are not uncommon in ethical decision making. After all, situations that warrant full-scale ethical decision making, with all the steps that this entails, are, by definition, complicated. If they were not complex, the practitioner could have resolved the situation easily and simply at an earlier stage. Thus it should not be surprising that many ethical dilemmas related to boundaries and dual relationships remain controversial even after practitioners have taken the time to examine them thoroughly and systematically. Such is the nature of ethical dilemmas.

Once the decision is made, human service professionals should always be careful to document the steps involved in the decision-making process. Ethical decisions are just as much a part of practice as clinical, community, organizational, and policy interventions, and they should become part of the record (Luepker 2002; Kagle and Kopels 2008; Moline, Williams, and Austin 1998; Sidell 2011). This is simply sound professional practice. Both the practitioner involved in the case and other professionals who may become involved in the case (e.g., supervisors, administrators, defense counsel) may need access to these notes at some time in the future to assess the practitioner's actions and judgment. As the NASW *Code of Ethics* (2008) states, "Social workers should include sufficient and timely documentation in re-

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cords to facilitate the delivery of service and to ensure continuity of services provided to clients in the future" (standard 3.04[b]). Similarly, the ethics code of the American Psychological Association (2010) states, "Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law" (standard 6.01).

Preparing notes on the ethical decision-making process is extremely important in the event that the case results in an ethics complaint or legal proceedings (for example, a lawsuit or licensing board complaint filed against the practitioner). Carefully written notes documenting the professional's diligence can be protection from allegations of malpractice or negligence (Reamer 2003a).

Professionals need to decide how much detail to include in their documentation. Too much detail can be problematic, particularly if the practitioner's records are subpoenaed. Sensitive details about the client's life and circumstances may be exposed against the client's wishes. At the same time practitioners can encounter problems if their documentation is too brief and skimpy, especially if the lack of detail affects the quality of care provided in the future by other professionals. In short, practitioners need to include the level of detail that facilitates the delivery of services without exposing clients unnecessarily, consistent with generally accepted standards in the profession. According to the NASW *Code of Ethics* (2008), "Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services" (standard 3.04[c]).

7. *Monitor, evaluate, and document the decision.* Whatever ethical decision a practitioner makes about the management of boundary issues is not the end of the process. In some respects it constitutes the beginning of a new stage. Human service professionals should always pay close attention to and evaluate the consequences of their ethical decisions related to boundaries. This is important in order to be accountable to clients, employers, funding sources, and other relevant third parties and, if necessary, to provide documentation in the event of an ethics complaint or lawsuit. This may take the form of routine case monitoring, recording, or more extensive evaluation using the variety of research tools now available to practitioners (Bloom,

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Fischer, and Orme 2009; Corcoran and Fischer 2000; Nugent, Sieppert, and Hudson 2001; Vonk, Tripodi, and Epstein 2007).

As I noted in the preceding discussion, it would be a mistake to assume that systematic and ethical decision making will always produce clear and unambiguous results. To expect this would be to misunderstand the nature of ethics. The different theoretical perspectives of human service professionals, their personal and professional experiences, and their biases will inevitably combine to produce differing points of view. This is just fine, particularly if we are confident that sustained dialogue among practitioners about the merits of their respective views is likely to enhance their understanding and insight. As in all other aspects of practice, the process is often what matters most. As Jonsen notes, ethics guidelines by themselves "are not the modern substitute for the Decalogue. They are, rather, shorthand moral education. They set out the concise definitions and the relevant distinctions that prepare the already well-disposed person to make the shrewd judgment that this or that instance is a typical case of this or that sort, and, then, decide how to act" (1984:4).

THE ROLE OF PRACTITIONER IMPAIRMENT

In a significant percentage of cases involving boundary violations and inappropriate dual relationships, we find evidence of some form of practitioner impairment. In recent years the subject of impaired professionals has received increased attention (Berliner 1989; Celenza 2007; Gutheil and Brodsky 2008; Kilburg, Nathan, and Thoreson 1986; Laliotis and Grayson 1985; McCrady 1989; Reamer 2006a, 2009b; Syme 2003).

Organized efforts to address impaired employees began in the late 1930s and early 1940s after Alcoholics Anonymous was formed and in response to the need that arose during World War II to sustain a sound workforce. These early occupational alcoholism programs eventually led, in the early 1970s, to the emergence of employee assistance programs, designed to address a broad range of problems experienced by employees. Also, in 1972 the Council on Mental Health of the American Medical Association issued a statement that said that physicians have an ethical responsibility to recognize and report impairment among colleagues. In 1976 a group of attorneys recovering from alcoholism formed Lawyers Concerned for Lawyers to address chemical

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dependence in the profession, and in 1980 a group of recovering psychologists began a similar group, Psychologists Helping Psychologists (Kilburg, Nathan, and Thoreson 1986).

Social work's first national acknowledgment of the problem of impaired practitioners came in 1979, when NASW issued a public policy statement concerning alcoholism and alcohol-related problems (Commission on Employment 1987). By 1980 a nationwide support group for chemically dependent practitioners, Social Workers Helping Social Workers, had formed. In 1982 NASW formed the Occupational Social Work Task Force, charged with developing a strategy to deal with impaired NASW members. Two years later the NASW Delegate Assembly issued a resolution on impairment, and in 1987 NASW published the *Impaired Social Worker Program Resource Book* to help members of the profession design programs for impaired social workers. The introduction to the resource book states:

> Social workers, like other professionals, have within their ranks those who, because of substance abuse, chemical dependency, mental illness or stress, are unable to function effectively in their jobs. These are the impaired social workers. . . . The problem of impairment is compounded by the fact that the professionals who suffer from the effect of mental illness, stress or substance abuse are like anyone else; they are often the worst judges of their behavior, the last to recognize their problems and the least motivated to seek help. Not only are they able to hide or avoid confronting their behavior, they are often abetted by colleagues who find it difficult to accept that a professional could let his or her problem get out of hand.
>
> (6)

More recently, strategies for dealing with professionals who encounter boundary challenges that stem from problems such as substance abuse, mental illness, and emotional stress have become more prevalent. Professional associations and informal groups of practitioners meet periodically to discuss the problem of impaired colleagues and to organize efforts to address the problem.

Both the seriousness of impairment among human service professionals and the forms it takes, especially related to boundary violations and crossings, vary. Impairment may involve failure to provide competent care or violation of the profession's ethical standards, such as serious boundary violations involving sexual misconduct with a client (Reamer 1995b, 1997). It may also

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take such forms as providing flawed or inferior psychotherapy to a client or failure to carry out professional duties as a result of substance abuse or mental illness (Johnson and Stone 1986; Koeske and Koeske 1989). Lamb and colleagues provided one of the earliest, and still relevant, definitions of impairment among professionals:

> Interference in professional functioning that is reflected in one or more of the following ways: (a) an inability and/or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior; (b) an inability to acquire professional skills in order to reach an acceptable level of competency; and (c) an inability to control personal stress, psychological dysfunction, and/or excessive emotional reactions that interfere with professional functioning.
>
> (1987:598)

Although we have no precise estimates of the extent of impairment among human service professionals, speculative data are available based on pioneering research that began in the 1980s (Besharov 1985; Bissell and Haberman 1984; Bullis 1995). For example, in the foreword to the *Impaired Social Worker Resource Book*, published by the Commission on Employment and Economic Support of the National Association of Social Workers, the commission chair states, "Social workers have the same problems as most working groups. Up to 5 to 7 percent of our membership may have a problem with substance abuse. Another 10 to 15 percent may be going through personal transitions in their relationships, marriage, family, or their work life" (1987:4). The report goes on to conclude, however, that "there is little reliable information on the extent of impairment among social workers" (6).

The earliest prevalence studies among psychologists suggested a significant degree of distress within the profession. In a study of 749 psychologists, Guy, Poelstra, and Stark (1989) found that 74.3 percent reported "personal distress" during the previous three years, and 36.7 percent of this group believed that their distress decreased the quality of care they provided to clients. Pope, Tabachnick, and Keith-Spiegel report that 62.2 percent of the members of Division 29 (Psychotherapy) of the American Psychological Association admitted to "working when too distressed to be effective" (1988:993). In their survey of 167 licensed psychologists, Wood and colleagues (1985) found that nearly one-third (32.3 percent) reported experiencing depression or burnout to an extent that interfered with their work. Wood and colleagues also found that a significant portion of their sample reported being aware of colleagues

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whose work was seriously affected by drug or alcohol use, sexual overtures toward clients, or depression and burnout. In addition, evidence suggests that psychologists and psychiatrists commit suicide at a rate much higher than the general population (Farber 1983, cited in Millon, Millon, and Antoni 1986).

In an important interdisciplinary study, Deutsch (1985) found that more than half her sample of social workers, psychologists, and master's-level counselors reported significant problems with depression, which can be a correlate of boundary problems. Nearly four-fifths (82 percent) reported problems with relationships, 11 percent reported substance abuse problems, and 2 percent reported suicide attempts.

In a groundbreaking, comprehensive review of a series of empirical studies focused specifically on sexual contact between therapists and clients, K. S. Pope (1988) found that the aggregate average of reported sexual contact is 8.3 percent by male therapists and 1.7 percent by female therapists. Pope reports that one study (Gechtman and Bouhoutsos 1985) found that 3.8 percent of male social workers admitted to sexual contact with clients.

Impairment among professionals is the result of various causes. Stress related to employment, illness or death of family members, marital or relationship problems, financial problems, midlife crises, physical or mental illness, legal problems, and substance abuse may lead to impairment (Guy, Poelstra, and Stark 1989; Thoreson, Miller, and Krauskopf 1989). Stress induced by professional education and training can also lead to impairment, because of the close clinical supervision and scrutiny students receive, the disruption in students' personal lives caused by the demands of schoolwork and internships, and the pressures of academic programs (Lamb et al. 1987).

According to Wood and colleagues (1985), psychotherapists encounter special sources of stress that may lead to impairment because their therapeutic role often extends into nonwork areas of their lives (such as relationships with family members and friends) and because of the lack of reciprocity in relationships with clients (therapists are "always giving"), the slow and erratic nature of therapeutic progress, and personal issues that therapeutic work with clients may stir up. Psychotherapists who feel unusually stressed may cope in destructive ways that lead to boundary violations, for example, by seeking solace in an intimate relationship with an appealing client. As Kilburg, Kaslow, and VandenBos observe,

> The stresses of daily life—family responsibilities, death of family members and friends, other severe losses, illnesses, financial difficulties, crimes of all

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> kinds—quite naturally place mental health professionals, like other people, under pressure. However, by virtue of their training and place in society, such professionals face unique stresses. And although they have been trained extensively in how to deal with the emotional and behavioral crises of others, few are trained in how to deal with the stresses they themselves with face. . . . Mental health professionals are expected by everyone, including themselves, to be paragons. The fact that they may be unable to fill that role makes them a prime target for disillusionment, distress, and burnout. When this reaction occurs, the individual's ability to function as a professional may become impaired.
>
> (1988:723)

Unfortunately, relatively little is known about the extent to which impaired human service professionals, especially those who violate boundaries or engage in unethical dual relationships, voluntarily seek help for their problems. Few ambitious studies have been conducted. Guy, Poelstra, and Stark (1989) found that 70 percent of the distressed clinical psychologists they surveyed sought some form of therapeutic assistance. One-fourth (26.6 percent) entered individual psychotherapy, and 10.7 percent entered family therapy. A small portion of this group participated in self-help groups (3.4 percent) or was hospitalized (2.2 percent). Some were placed on medication (4.1 percent). Exactly 10 percent of this group temporarily terminated their professional practice.

These findings contrast with those of Wood and colleagues (1985), who found that only 55 percent of clinicians who reported problems that interfered with their work (sexual overtures toward clients, substance abuse, depression, and burnout) sought help. Two-fifths (42 percent) of all clinicians surveyed, including impaired and unimpaired professionals, reported having offered help to impaired colleagues at some point or having referred them to therapists, according to Wood and colleagues. Only 7.9 percent of the sample said they had reported an impaired colleague to a local regulatory body. Two-fifths (40 percent) were aware of instances in which they believed no action was taken to help an impaired colleague.

We may draw several hypotheses concerning the reluctance of some impaired human service professionals to seek help and the reluctance of their colleagues to confront them about their problems. Until recently, professionals were hesitant to acknowledge impairment within their ranks because they feared how practitioners would react to confrontation and how such confron-

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tation might affect future working relationships among colleagues (Bernard and Jara 1986; McCrady 1989; Prochaska and Norcross 1983; Wood et al. 1985). As VandenBos and Duthie (1986) note,

> The fact that more than half of us have not confronted distressed colleagues even when we have recognized and acknowledged (at least to ourselves) the existence of their problems is, in part, a reflection of the difficulty in achieving a balance between concerned intervention and intrusiveness. As professionals, we value our own right to practice without interference, as long as we function within the boundaries of our professional expertise, meet professional standards for the provision of services, and behave in an ethical manner. We generally consider such expectations when we consider approaching a distressed colleague. Deciding when and how our concern about the well-being of a colleague (and our ethical obligation) supersedes his or her right to personal privacy and professional autonomy is a ticklish matter.
>
> (1986:212)

Thoreson and colleagues (1983) also argue that impaired professionals sometimes find it difficult to seek help because of their mythical belief in their infinite power and invulnerability. The involvement of a large number of psychotherapists in private practice exacerbates the problem because of the reduced opportunity for colleagues to observe their unethical conduct, including boundary violations and inappropriate dual relationships (Reamer 2003b).

In Deutsch's valuable 1985 study, a diverse group of therapists who acknowledged having personal problems gave a variety of reasons for not seeking professional help, including believing that an acceptable therapist was not available, seeking help from family members or friends, fearing exposure and the disclosure of embarrassing confidential information, concern about the amount of effort required and about the cost, having a spouse who was unwilling to participate in treatment, failing to admit the seriousness of the problem, believing that they should be able to work out their problems themselves, and assuming that therapy would not help.

It is important for professionals to design ways to prevent impairment and respond to impaired colleagues, especially those whose impairment leads to serious boundary violations and inappropriate dual relationships. They must be knowledgeable about the indicators and causes of impairment, so that they can recognize problems that colleagues may be experiencing. Practitioners must also be willing to confront impaired colleagues constructively,

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offer assistance and consultation, and, if necessary as a last resort, refer the colleague to a supervisor or local regulatory body or professional association.

Over time various professions' codes of ethics have acknowledged and address the issue of professional impairment. In social work, for example, in 1992 the president of NASW created the Code of Ethics Review Task Force (which I chaired), which proposed adding new standards to the code on the subject of impairment. The approved additions became effective in 1994 and were then revised slightly and incorporated in the current NASW *Code of Ethics*:

> Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.
>
> (standard 4.05[a])

> Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.
>
> (standard 4.05[b])

> Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action.
>
> (standard 2.09[a])

> Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.
>
> (standard 2.09[b])

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Other human service professions have established similar standards. For example, the *Code of Ethics* of the AAMFT (2001) states, "Marriage and family therapists [should] seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment" (standard 3.3). The ACA *Code of Ethics* (2005) states,

> Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients.
>
> (standardC .2.g)

Although some cases of impairment must be dealt with through formal adjudication and disciplinary procedures, many cases can be handled primarily by arranging therapeutic, rehabilitative, and educational services for distressed and impaired practitioners.

As human service professionals increase the attention they pay to the problem of impairment and its relationship to boundary violations, they must be careful to avoid assigning all responsibility to the practitioners themselves. Professionals must also address the environmental stressors and structural factors that can cause impairment. Distress is often the result of the unique challenges in the human services, and remedial resources often are inadequate. Caring professionals who are overwhelmed by the difficulties of their clients—chronic problems of poverty, substance abuse, child abuse and neglect, hunger and homelessness, and mental illness—are prime candidates for high degrees of stress, compassion fatigue, and burnout. Insufficient funding, the stresses of managed care, unpredictable political support, and public skepticism of professionals' efforts often lead to low morale and high stress (Jayaratne and Chess 1984; Maslach 2003). Thus, in addition to responding to the individual problems of impaired colleagues, practitioners must confront the environmental and structural problems that can cause the impairment in the first place. This comprehensive effort can also help to reduce

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unethical behavior and professional misconduct, particularly in the form of boundary violations and inappropriate dual relationships.

There is no question that human service professionals have developed a richer, more nuanced understanding of boundary issues in the profession. To further enhance this understanding, professionals must examine dual relationships that are exploitative and those that are more ambiguous. Practitioners' firm grasp of boundary issues involving their intimate relationships with clients and colleagues, management of their own emotional and dependency issues, pursuit of personal benefit, altruistic gestures, and responses to unanticipated and unavoidable circumstances will increase their ability to protect clients, colleagues, and themselves. Most important, skillful management of boundary issues will enhance human service professionals' integrity, one of the hallmarks of a profession. Skillful management of these issues will also reduce the likelihood of ethics complaints and malpractice claims.

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