**Reading Information**

Read Chapter 7: “Boundaries, Roles and Limits”(chapter 7 is below)

Review the following website for standards that address the concepts of boundaries and multiple relationships:

NOHS. Ethical Standards for Human Service Professionals. Retrieved from <http://www.nationalhumanservices.org/ethical-standards-for-hs-professionals> (This is attached)

Read Chapter 1 from the following book found in the Library:

Reamer, F. G. (2012), Boundary issues and dual relationships in the human services. New York: Columbia University Press. (This is attached)

Chapter 7 will explore the concept of boundaries in its entirety. You will discover the definitions and functions of boundaries and roles in professional helping relationships, as well as the reasoning why boundaries are essential to those relationships. You will also explore the difficulties caused by entering into dual or multiple relationships with clients and common client responses to boundary and limit setting. You will also explore the unique difficulties presented by rural or small communities and how to handle issues such as handle gift giving, touch, and sexual attraction.

The chapter from the Reamer book will further illustrate how boundary issues can impact the helping relationship, while your review of the standards will acquaint you with the requirements of the NOHS Code regarding boundary issues.

**Becoming an Ethical Helping Professional: Cultural and Philosophical Foundation**

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**ISBN: 9781119087922**

[**https://kaplan.vitalsource.com/#/books/9781119087922**](https://kaplan.vitalsource.com/#/books/9781119087922) **(see chapter 7 below)**

**Chapter Seven
BOUNDARIES, ROLES, AND LIMITS**

*Dibs suddenly stood up. “No!” he shouted. “Dibs no go out of here. Dibs no go home. Not never!”*

*“I know you don't want to go, Dibs. But you and I only have one hour every week to spend together here in this playroom. And when that hour is over, no matter how you feel about it, no matter how I feel about it, no matter how anybody feels about it, it is over for that day and we both leave the playroom.”*

—Virginia Axline, Dibs: In search of self

**CHAPTER ORIENTATION**

Taking on a professional helping role in someone's life has immediate responsibilities and implications that far outlast the actual professional relationship. In this chapter, we invite you to consider practical, clinical, professional, and personal perspectives on the roles and boundaries that professionals must orchestrate in their service to clients. The potential for subtle or blatant abuse of helping relationships is considerable. We hope that examining the dynamics from every angle possible will at least reduce the risks of inadvertent harm. This chapter is all about boundaries.

Even if we lived in one nice, discrete sphere labeled Personal and traveled to a completely different sphere labeled Professional for work, boundaries would be challenging because we would be bringing our whole selves back and forth. But of course, our spheres are not discrete. Our lives are much more complex, interconnected, and fluid than that. The many challenging rural and cultural boundary implications cannot be lightly dismissed either, and deserve a bit of specific scrutiny. Specifically, in this chapter you will have the opportunity to consider:

* the definitions and functions of roles and boundaries in human relationships;
* the many reasons boundaries are absolutely central to ethical practice;
* the contributing dynamics of transference and countertransference;
* client responses to boundary setting;
* the realities and concerns about multiple roles;
* ways to deconstruct the generic term multiple roles to determine a wise course of action;
* gift giving and receiving, self- disclosure, and considerations about touch;
* methods for assessing benefit and harm;
* rural and community concerns;
* the dynamics and realities of sexual attraction.

**INTRODUCTION TO ROLES, BOUNDARIES, AND RELATIONSHIP RULES**

In exchanges between humans, there are implicit and explicit rules for interaction that maintain the fabric of culture and the integrity of each individual. We begin learning these relationship rules at birth, and they continue to guide our interactions throughout our lives.

Relationship rules create boundaries within and around all human relationships. Often, we only become consciously aware of these boundaries when they are violated. These boundary rules include the “proper” amount of interpersonal space for various types of interactions (business, professional, service, sales, romantic, familial). They include expectations for verbal styles and output, based on such factors as gender, power, age, and relationship (e.g., Tannen, 1990; e.g., Young- Eisendrath, 1993). They also include rules about dress, touch, food consumption, appropriate work and recreation, sleeping arrangements, and probably thousands of other aspects of human society, including the boundaries between “the personal” and “the professional” (Pipes, Holstein, & Aguiree, 2005).

These rules and resulting boundaries have obligations as well as privileges associated with them (Kitchener, 2000). There are cultural differences in the role expectations (Mar cussen & Piatt, 2005), but regardless of these differences, the roles carry weighty expectations. All human relationships or interactions involve risk. You might place your trust in a painter who ultimately fails to listen and paints your kitchen the wrong shade of lime green or orange. You might have welcomed a neighbor's pet into your yard, only to find the pet loves to dig in your precious flowerbeds. Even the briefest encounters have implicit or explicit boundaries and rules, which if broken, can be damaging or even disastrous. For example, we literally trust our lives to others operating motor vehicles every time we drive or even walk along a roadside. We trust mail- order pharmacies to send us the right medications, in the right dosage. Some of these rules have the weight of law behind them, but others do not. Either way, we trust other people to obey the rules and laws as we interact with them, and if the trust is broken, there are consequences (Kavathatzopoulos, 2005). When we fail to live up to the obligations—or violate the privileges—at the very least, there is discomfort and confusion. At the worst, there is pain, broken relationships, lawsuits, and other collateral damage.

In [Chapter 1](https://jigsaw.vitalsource.com/books/9781119087922/epub/OPS/c01.xhtml), we talked about the social origins of professionalism. Professionals are expected to perform their duties objectively and with client welfare as their highest concern. It is a widely held assumption that certain personal relationships will, almost by definition, compromise professional objectivity. Familial and sexual relationships, as well as long- term or deep friendships, have many role expectations that come into direct conflict with roles that demand objectivity and equal treatment.

**Pause for Reflection**

*Close personal and familial relationships give our lives meaning and connection. These relationships are where we hope to find shelter, loyalty, compassion, and ready forgiveness. In his poem, The Death of the Hired Man, Robert Frost (Latham, 1979) wrote, “Home is where, when you have to go there, they have to take you in” (p.38). How do you imagine your professional life intersecting with your personal life? Are you likely to seek friendships in your workplace? Romantic partners? What concerns do you experience when coworkers are also friends or lovers? How do you create and maintain boundaries that keep your home and your relationships safe and healthy?*

Maintaining healthy boundaries around personal and professional relationships is an important component of burnout prevention as well as professional fidelity. Although they may offer the biggest challenges, personal and familial roles are not the only roles with expectations that might conflict with professional role demands. As an individual, you have many associations with other people in your life. By definition, each of these relationships has role expectations, boundaries, and interests—and many will have competing demands on your allegiance, time, and energy.

**WHY ALL THE FUSS ABOUT BOUNDARIES AND RELATIONSHIPS?**

As you become a mental health or helping professional, this new role will influence your consideration of other potential roles in your life. Some of these considerations may surprise you. Some may seem overly protective or misguided whereas some may simply seem like good common sense. In most forms of counseling, boundary concerns are central because the trusting professional relationship itself is part of the healing process (Gelso & Hayes, 1998; Rogers, 1958). In this sense, a counseling relationship is both professional and very intimate.

Any intimate relationship has emotional risk. When the rules of interaction are broken in our closest relationships, the damage can be painful and extensive. Even small or unintended failures can take significant time and energy to repair. If the rules are extensive and/or repeatedly broken, chances increase that the relationship will be permanently altered or will end.

Sometimes intimate relationships are enhanced when the parties in the relationships have multiple roles in each other's lives. Romantic partners or friends often find their relationships improved if both members are interested in similar hobbies, share membership in the same faith community, or become active in supporting a similar political cause. Parents can sometimes improve relationships with children by coaching the soccer team, leading the scout troop, or being a classroom parent. Of course, intimate relationships can also be complicated or harmed by overlapping roles. The role expectations could run counter to each other, or disappointment or failure in one set of roles could affect the other relationship. If your mom is your soccer coach, and as a good mom she knows how much you want to play and improve, but as a soccer coach she knows you aren't good enough to be a starter, there will be tension in both relationships.

As we noted in the introduction, it might be easier if our personal lives and our professional lives never intersected—but that is rarely the case. Some might even argue that the complexities of our boundary intersections keep life interesting. Regardless, we would argue that large quantities of awareness and integrity are necessary to manage boundaries between the personal and the professional. For instance, when two or more mental health professionals are also in close personal or familial relationships, issues such as client confidentiality need to be addressed carefully with all stakeholders, including clients. It is not uncommon for mental health practitioners to be married, or to have a practice that includes a sibling or parent. The public nature of professional life raises boundary issues for those involved, those affected, and those observing (see Digressions for Deliberation 7.1 for a case in point).

**DISTINCTIVE ASPECTS OF PROFESSIONAL HELPING RELATIONSHIPS**

Counseling relationships have dimensions and dynamics that make them unlike any other personal or professional relationship. Because of this, counselors have especially significant fidelity responsibilities. We list some of the main differences in the following paragraphs:

* Counseling relationships have aptly been described as one way intimacies (Shirley Emerson, 1995). Significant relationship risks are incurred by clients as they bare their souls, their needs, or their foibles while being dependent on the counselor to honor the trust. Professionals do not engage in reciprocal depth of self- disclosure. Any self- disclosure should be done in the service of the helping relationship, with the client's best interest as a guide.
* Just as the intimacies are one way (client to professional), the ethical boundary responsibilities are also one way (professional to client). As Bernstein and Hartsell (2000) note, “It is unethical for a therapist to become involved in a dual relationship with the client, but the client can violate boundaries with impunity” (p.62).
* There is a power differential in the helping relationship. The client is seeking help from a professional who is assumed to have knowledge and skills. The therapist comes to know the client's fears and weaknesses. The combination of professional knowledge and personal knowledge make the therapist potentially very powerful in the client's life (Cummings, 2000).
* Professional helping relationships are resource dependent. Clients cannot simply have as much time as they might like with their counselors. Managed care, sheer numbers of students, insurance rules, agency policies, and other financial practicalities define and limit the quantity and quality of the therapy relationship (Michels, 2001).
* Helping relationships are outcomes driven. Even if finances are no concern, both the number and length of sessions are determined by the counselor's best judgment and accepted professional practices (e.g., Stricklin- Parker & Schneider, 2005).

In addition to these overt dimensions that make professional counseling relationships unique, there are other powerful dynamics that operate at the unconscious level and contribute to boundary concerns. These two related concepts, transference and countertransference, are explained next.

**Digressions for Deliberation 7.1**

**The Authors' Boundary Challenges**

For less observant readers, it may come as a surprise to learn that the authors of this text are married. We have worked together as writers, professors, researchers, psychological evaluators, and counselors. A generation ago, due to nepotism laws, some of these shared roles would not have been legally possible in some states and, though strides are being made on this front (Foster, 1993), they are still the source of occasional suspicion and awkwardness. What if there is a divisive issue in a faculty meeting and a close vote is expected? Will we be seen as voting independently or as an automatic voting block? What if a student offends one of us or performs very poorly in one of our courses? Will that student worry about the effects not only on one of us, but on the other as well? What if a student needs to complain about being treated unfairly by one of us? Will we always leap to each other's defense?

In our clinical work, clients who know we are married sometimes assume we talk about them to each other. In public, they might approach us and begin talking about issues and concerns they raised in a counseling session with one of us. This sort of behavior was initially quite surprising.

We've found that there are ethical practices we can use to prevent or mitigate the potential harm our spousal relationship might have on students, colleagues, and clients. For instance, we are explicit in our informed consent process about the fact that we do not ordinarily discuss our professional work with each other. We explain that if we believe such discussion would be helpful, we will talk it over with our client first. In classes with new students, we make a point to note that we are married, and work together, and give students permission to talk about that, either in class, with us directly, or with another faculty person, should it pose any problems for them. And our colleagues …? Faculty alliances form over issues of great import, such as resource allocations, and slightly lesser import, such as who should make the coffee. We disagree as often as we agree, which is a comfort to those worried about a voting block—but perhaps less of a comfort to those who are more conflict avoidant.

Finally, we've discovered that the multiple- roles impact is a two- way street. We have to make sure we also take steps to keep the professional demands we share from taking a destructive toll on our personal lives.

**Transference**

Sigmund Freud (Freud, 1949) first described, and thus got naming privileges for, the transference phenomenon. Transference occurs when clients project unconscious material onto their therapist and into the professional relationship—usually related to unfinished business with early childhood caretakers and authority figures. Harry Stack Sullivan's concept of parataxic distortion (H.S. Sullivan, 1953) is a similar concept, but is not limited to the therapeutic relationship. Parataxic distortion occurs when our perceptions of others are distorted by our past, our own needs, and/or our unconscious fantasies. We then relate to these others, not on the basis of who they are, but on our projections of who they are.

Certain approaches in counseling utilize this projective phenomenon directly by allowing the transference to develop and then helping the client see the projective and inaccurate quality of the transferential beliefs. Psychoanalysts and others who work therapeutically with transference have extensive training and have sought their own analytic therapy as well (J. Sommers- Flanagan & Sommers- Flanagan, 2004b). Not every mental health professional will directly work with transference within the therapeutic relationship, but we believe that to some extent, transference is operative in most helping relationships. Transference also has significant emotional weight. Therefore, clients will not only assume many things about you and how you behave, but they will also likely have strong feelings about these assumptions. Contact outside the professional relationship can add unnecessary, confusing, or even harmful dimensions to clinical work and the transference process. Consider the case of Lin and Ginny.

**Case Example**

Lin, a 40- something counselor in a university counseling center, was seeing an attractive, athletic young woman named Ginny. Ginny was insightful and eager to work out her conflicted relationship with her mother, which she believed was contributing to her struggles with body image and mild eating disordered behaviors. Ginny loved her counseling and made it clear that she admired Lin and her work. Although Lin's approach in her work with Ginny included cognitive behavioral strategies, Lin was well aware of the transference dimensions in her therapeutic relationship with Ginny. Unbeknownst to either of them, both Lin and Ginny had signed up for a campus recreation class for beginning tennis. It was a small class, with members often paired to work on their skills. Fortunately, Lin was not paired with Ginny the first day, but both were keenly aware of the other. Lin knew this would be an issue for Ginny, so she took some time with a colleague to talk over the best course of action. Together, they went over the options:

1. Lin could continue the tennis class and conduct herself as if she did not know Ginny from any other context. She could limit contact with Ginny as much as possible, and try to get over her own self- consciousness of being in a tennis class with a young, athletically able client who would likely be closely watching Lin's attempts to learn tennis. In this option, she would simply allow Ginny to talk about the tennis class if she chose to.
2. Similar to the first option, Lin could stay in the class, but consciously use the class interactions to further Ginny's work on her body image and relationship with her mother.
3. Lin could drop the tennis class for now and simply tell Ginny nothing. If Ginny brought it up, Lin could indicate that she had found the tennis class didn't fit in her schedule, or life, right then.
4. Lin could drop the tennis class and talk with Ginny about the decision. Lin could explain to Ginny that the class would be available later, and that because her time with Ginny was limited and very important, she (Lin) didn't want to complicate things by the extra contact.

You may have a variety of reactions to this scenario. We'll refer back to it later in the chapter, but in the meantime, put yourself in Lin's shoes. What do you imagine yourself wanting to do? What about if you were Ginny?

Of course, transference and/or parataxic distortions are constantly in flux, acting and reacting in the context of dynamic interpersonal relationships. The antiquated notion that the counselor somehow stays objective and neutral in this process has been displaced by an awareness that counseling techniques and relationships affect both the counselor and the client in a mutually influential set of interactions (Renik, 1993). Therefore, we must look at the other side of the coin.

**Countertransference**

In the thirteenth century, the Sufi poet, Rumi wrote, “Many of the faults you see in others, dear reader, are your own nature reflected in them. As the Prophet said, the faithful are mirrors to one another” (Helminski, 2000, p.18). In the narrowest sense, countertransference is an unconscious reaction on the part of the professional to the unconscious material transferred onto the helper by the client (Freud, 1966). More broadly, countertransference refers to the process by which we project our unconscious unfinished business onto our clients (L.S. Brown, 2001). Sometimes this is in reaction to our clients' transferential materials, but sometimes, it happens just because they directly trigger unconscious reactions, or (to use sophisticated clinical language) push our hidden buttons. Even more broadly, countertransference is sometime defined as any reaction the counselor has toward the client, or a supervisor (Dass- Brailsford, 2003). As you may have experienced, some clients will be much harder to care about, work with, and to respect than others. For no obvious reason, you might feel angry, protective, overly affiliative, or sexually aroused when working with certain clients.

Countertransference- based emotions may impair your objectivity—your determination to be fair and treat all of your clients with the same respect. When strong emotions have been triggered, a very common human reaction is to react impulsively. What would this acting out look like in the counseling world? It might involve thinly disguised story telling about the client's amazing or disgusting life details, or talking to colleagues in greater detail or length about the client than you usually do. It could also involve “accidentally” double- scheduling, being late to sessions, going over time, cutting sessions short, hasty referring, “innocent” flirting, or early termination. And if left unaddressed, countertransference might lead to boundary breaks that cause further loss of objectivity, and harm.

**Digressions for Deliberation 7.2**

**Counselors as Projective Targets—A Protective Image**

In our teaching, we take the stance that without Rogers' core conditions of congruence, empathy, and nonjudgmental positive regard in the counseling relationship (Rogers, 1957), chances for therapeutic change are very slim (J. Sommers- Flanagan & Sommers- Flanagan, 2003). Students wonder aloud about how any professional can work authentically and caringly with racist or homophobic clients, or child abusers, murderers, or pedophiles. Peace activists worry that they could not work with pro- war clients. Atheists, with people of various faiths, hunters with vegetarians. We acknowledge that into almost everyone's life will come a few clients with whom they simply cannot work (Mehlman & Glickauf- Hughes, 1994), but assure students they will be amazed at the magic of counseling; astounded at how often they will find within themselves empathy, compassion, and positive regard for clients very different than themselves.

Clients will not always be congruent, empathic, and/or nonjudgmental in return. In fact, sometimes they will be angry, accusing, mocking, malicious, insulting, flirtatious, whiney, blaming, and otherwise quite unpleasant. We offer our students an image for handling the intense emotional energy that can fly around the room during sessions, warning them that sometimes, clients aim flaming arrows at them with precision born of desperation and finely developed defenses.

This is the image: Deep inside you, there is a warm, empathic beating heart and a keen, insightful mind. Your professional skills and talents provide you with an impenetrable shield over these vital organs. This shield allows empathy and wisdom to flow out, but does not allow mortally wounding arrows in. The shield has a thick layer of soft, downy material—similar to a huge feather quilt or that new impact- absorbing material developed by NASA. You can catch anything that comes at you without fear of mortal emotional wounding. You don't have to judge, counter attack, or seek revenge. You have control of your voice, your words, your facial expressions—all can remain compassionate and reflective. Even when directly attacked, you have protective coverings that allow you to relax and see the pain behind the attack. You understand that you are standing in for life's injustices, disappointments, and cruelty. You can be a safe container, offering patience and thoughtful, cautious interpretations that gently hold up the mirror.

Hopefully, you will take our advice from [Chapter 5](https://jigsaw.vitalsource.com/books/9781119087922/epub/OPS/c05.xhtml), and have a very well- developed informed consent process that addresses boundaries and potential nonprofessional contact. Explaining boundaries and roles can be challenging. We provide an example in Application 7.1. However, even the perfect paragraph would not allay all the transferential assumptions clients have about your behaviors, or free you from your own countertransferential impulses. Clarity is essential, and keeping your word once you have shared your policies is also essential—and sometimes difficult to do.

**Client Indignation or Relief**

Defining and keeping boundaries will often have an impact on clients emotionally. It is natural that clients will like and care about their counselors. Some will hope for special favors, or want to become friends or even lovers (Heyward, 1994). We have had adolescent clients ask how we would feel about adopting them. This positive regard and wish for closeness could be considered positive transference, but that may not be the only way to think about it. Instead of being unconscious, it might be a conscious recognition that the therapist is an accepting, caring person with great listening skills and a nice office. Who wouldn't want such a friend or lover? Who wouldn't fantasize about what a great parent this kind person would be?

This urge for closeness with one's counselor—whether driven by unconscious needs and fantasies, or a more conscious response to being listened to and cared for—is a vulnerable emotional reaction to the helping process. In response to this vulnerability, the ethical professional must find wise and gentle ways to explain these necessary professional boundaries so that clients do not feel embarrassed, judged, or rejected. Boundary breaking and keeping both can elicit strong client reactions. There are popular press books that detail the pain and anger of damaging boundary breaks in helping relationships (Strean, 1993). There are also books that express deep disdain and disappointment in counselors who would not break boundaries that the client longed to have broken (Heyward, 1994).

Of course, not all clients long for special treatment, friendship, or other connections to their counselor. In fact, many would find the thought of a personal connection or relationship with their counselor or therapist very threatening or unappealing. They want their counselor to be a safe confidant, interacting in strictly professional ways and staying out of their personal lives. They want their personal materials and interactions to stay private and contained. These clients are overtly relieved when assured that their counselors understands boundaries and will thus be trustworthy in this way (Epstein, 1994).

Whether they receive the information with relief or indignation, your clients deserve to know your boundary- keeping practices. Your informed consent process should include talking about boundaries and ethical concerns regarding nonprofessional interactions. We discuss this in the next section.

**ETHICS CODES AND TERMS**

Boundaries and roles have been addressed in various ways in the helping profession's ethics codes. Earlier ethics writers and codes referred to the ethical concerns of dual roles but, recognizing our increasingly complex and interconnected world, the terminology has morphed to multiple roles. Because of the complexities involved in defining and keeping professional boundaries, it is not surprising that when mental health professionals are asked to name the most difficult ethical concerns they face, they often name dual or multiple roles (K. Pope & V.A. Vetter, 1992).

The term multiple roles refers to an individual having two or more types of relationships, either simultaneously or sequentially, in another person's life. As noted previously, any kind of relationship between humans has role and boundary expectations, so if you have more than one type of relationship with someone, you will also have more than one set of role expectations. These everyday difficulties are not necessarily ethical problems. They become ethical concerns when one of the roles is a professional counseling role.

Herlihy and Corey (1997) write, “Multiple relationship issues exist throughout our profession and affect virtually all counselors, regardless of their work setting or the client population they serve…. No professional remains untouched by the potential difficulties inherent in dual or multiple relationships” (p.1). Further, most of us realize that no amount of rule making will ensure client safety. As Lazarus (2005) writes:

There are therapists who display poor social judgment, disordered thinking, and impaired reality testing. Some are sociopathic or have narcissistic or borderline personalities. But in my opinion, many of these unscrupulous practitioners will not be cowed or deterred by facing longer and more stringent rules and regulations. What we need are far more careful selection criteria so that we weed out these people before they enter into our graduate schools and training programs. (p.26)

Codes of ethics for many helping professions directly address multiple relationships, cautioning against most and forbidding a few.

**NASW *Code of Ethic***

1. **1.06 Conflicts of Interest**
	1. **(c)** Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)

**APA *Ethical Principles***

1. **3.05 Multiple Relationships:**
	1. A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person. A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists. Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.
	2. If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.
	3. When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third- Party Requests for Services.)
2. **3.06  Conflict of Interest:** Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.
3. **3.08  Exploitative Relationships:** Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as clients/patients, students, supervisees, research participants, and employees.

Interestingly, in ACA's most recent code the terms multiple roles and dual roles have been eliminated. After explicitly forbidding counselors, supervisors, and counselor educators certain roles in client or student lives, the code then states that nonprofessional relationships with clients, former clients, their romantic partners, or their family members should be avoided, except when the resulting interaction is potentially beneficial to the client. The wording of this portion of the code for counselors is provided in the following code example. It reflects a new way to approach the problems of boundaries and multiple relationships.

**ACA *Code of Ethics***

1. **A.5.d Potentially Beneficial Interactions**

When a counselor- client nonprofessional interaction with a client or former client may be potentially beneficial to the client or former client, the counselor must document in case records, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. Such interactions should be initiated with appropriate client consent. Where unintentional harm occurs to the client or former client, or to an individual significantly involved with the client or former client, due to the nonprofessional interaction, the counselor must show evidence of an attempt to remedy such harm. Examples of potentially beneficial interactions include, but are not limited to attending a formal ceremony (e.g., a wedding/commitment ceremony or graduation); purchasing a service or product provided by a client or former client (excepting unrestricted bartering); hospital visits to an ill family member; mutual membership in a professional association, organization, or community.

This wording places the evaluative burden on the professional who might be considering “nonprofessional interactions” or roles in addition to the counseling role. No guidance is given for multiple relationships that might be neutral or unavoidable, and no mention is made of counselors who might have an additional professional role in a client's life. There is certainly cause for concern when a counselor is considering two professional relationships with a client, such as being a client's teacher, coauthor, or employer. Later, the code specifically addresses the potential dual role of being someone's evaluator and counselor, counselor educator and counselor, and/or clinical super visor and counselor.

As is often the case with new ideas, the wording is a bit awkward and there are processes and questions that go unaddressed. Consider the preceding case example of Ginny and Lin. The ACA code indicates that counselors should avoid nonprofessional interactions except when the interaction is potentially beneficial to the client, but the code says nothing about the relative costs to the counselor or how to assess the potential benefits and harms. Perhaps one could argue that Ginny might have benefited from seeing Lin struggling to learn to play tennis. However, one could also argue that Ginny did not need the distraction. The extra transference- related issues might be too much to process in short term work. If Lin postponed her class, she is not making a huge sacrifice. But what if the campus was a small one and clients seemed to be everywhere, thus limiting the campus opportunities the small counseling center employees could take advantage of?

Ethics codes offer rules and guidance, but we will never be able to fully or rigidly codify the nuanced clinical and ethical dimensions of boundary concerns. This area of ethical behavior will require your attention throughout your professional life, and there will be many attempts to articulate ethical guidelines. We hope this chapter will at least raise the questions clearly and offer sound suggestions for practices that reflect the spirit of this latest guidance in the ACA code.

**BOUNDARIES, ROLES, TIMING, AND INFORMED CONSENT**

Basic explanations about boundaries should be provided during the first meeting with clients. Both in writing and in conversation, counselors need to explain the nature of the professional relationship and the primacy of this professional responsibility. We provide a sample paragraph in Applications 7.1, but settings and expectations vary, and professionals have unique ways of expressing this information.

In addition to differing demands due to settings and professional orientation, there will be variations in boundary discussions due to the unique attributes of individual clients. If your new client is a well- known public figure, teaches in a school where your children attend, conducts the symphony in which your wife plays violin, or sold you your last car, these boundary overlaps should be discussed.

The ACA ethics code injunction about nonprofessional contact with clients underscores the fact that informed consent is an ongoing process throughout the professional relationship. There are potential overlapping roles and boundaries before, during, and after counseling. Each point of concern is discussed in the following paragraphs.

**Applications 7.1**

**Example of Relationship- Boundary Explanation**

As my client, your welfare is my main concern. Our therapeutic relationship is primary—which means that I will not become your friend or enter into any other kind of relationship with you while we are working together, or after we have finished working together. We might see each other at social events, or at local businesses. You can decide if you want to say hello. I will treat our relationship as confidential, so I'll let you decide if you want to act like we know each other or not, and we can discuss any outside contact that happens, any time you like.

**Boundary Overlaps that Predate the Professional Relationship**

As you develop professional helping skills, your friends, family, romantic partners, and even grocery store clerks may suddenly decide you are just the person to talk with about deep, troubling private concerns. It is not an unusual assumption on their parts: people might date a massage therapist hoping for some great back rubs, or rejoice that their favorite cousin is studying medicine so their mysterious ailments can be healed. You are ethically free to share the professional knowledge you acquire in graduate school. You are also free to use your finely honed listening skills to enhance your personal relationships. However, you are not ethically free to begin professional counseling relationships with family, friends, colleagues, or business partners. In extreme circumstances, such a choice might be justifiable, but it would require extensive consultation and documentation. This distinction between sharing knowledge or listening well and professional counseling may seem confusing. Here are some examples to illustrate the difference.

* You might have a friend who reveals to you that she is in an abusive intimate relationship. As her friend, you can tell her what you have learned about such relationships. You can support her, listen to her, advocate for her, and investigate referrals and other possible resources. As you do these things, you make it clear to her that you are her friend, not her counselor, therapist, or social worker. You would not be able to have the professional objectivity necessary for a counseling relationship. Even if you could somehow muster that kind of boundary, and you became your friend's counselor, your friendship would be forever altered.
* Your spouse's business partner confides in you that she is deeply depressed. As she describes her symptoms, you are fairly certain she meets the criteria for major depression. You can express your concern and offer to help her locate a skilled mental health professional. But even if she insists you are the only person she could possibly trust, you would be on ethically shaky ground to take her as a client. Your obligation, should you agree to see her, would be first to her—not to your wife or her business concerns. What if her depression was so severe she was a business liability? What if she had thoughts of sabotaging the business? Would you warn your spouse? The entanglements could be damaging to everyone. And in the worst case scenario, if this client was disappointed in your work with her, she would have grounds for a malpractice case, because your choice to see her in the first place would not be considered the usual standard of care (see [Chapter 3](https://jigsaw.vitalsource.com/books/9781119087922/epub/OPS/c03.xhtml)).

The caution around taking clients with whom you have a preexisting relationship is not unconditional. To be absolutely certain, counselors could refuse to see anyone they had ever known or heard of, and refuse to see anyone related to anyone they had ever known or heard of. But in the real world, this is neither practical nor reasonable. Factors such as the extent of importance and intimacy of the preexisting relationship, the future trajectory of the preexisting relationship, and the nature of the client's need(s) must all be considered and weighed against the loss of objectivity and the potential harm to the preexisting relationship, as well as to the proposed professional relationship (Gottlieb, 1993).

**Case Example**

Franklin, a 56- year- old Vietnam veteran, is a licensed professional counselor working in private practice. His girlfriend, Amy, has a son, Jacob, who returned from combat in Iraq shaken, bitter, and changed. Amy wants Franklin to meet with Jacob a few times to talk over how he's doing. She knows that Franklin will be balanced, but also, that Franklin will level with Jacob about the psychological aftermath of combat. She trusts Franklin, and believes he would be the perfect counselor for Jacob. Amy also knows that Franklin runs an open- ended support group for military personnel returning from duty, as well as their family members. She wants to attend the group with Jacob. Jacob is lukewarm about the idea, at best. Amy asks Franklin to talk with Jacob, and convince him to come in for just a little bit of counseling.

What should Franklin consider in this complex request? He loves Amy, and would want to be of help to any of her family members. He doesn't know Jacob well, but he has a deep loyalty to returning veterans, and he knows he has the knowledge and skills necessary to help Jacob, should Jacob want help (Burham, 2004). Franklin also knows that Jacob is likely facing a long road toward the integration and healing necessary after combat trauma.

Franklin is aware that there are other resources besides him available to Jacob, but he is worried that Amy will be disappointed if he doesn't agree to see Jacob for counseling. It might seem to her that Franklin is denying Jacob something Franklin has, and Jacob needs. He is also worried that Jacob will refuse to pursue any other kind of help.

After consulting with a colleague, Franklin's solution was this: He talked to Amy about his professional ethics, and why there were ethical boundary concerns in her request. He then offered to take Jacob out for dinner, to reach out to him as a fellow veteran, and to do his best to connect Jacob with skilled help. He also decided that since the group he offered was open- ended, free of charge, the only such group in town, and conducted as a support group, he would let Amy decide for herself if she, or if she and Jacob, might want to attend. He did tell Amy that should she decide to attend, he would introduce her as his girlfriend, and Jacob as her son.

**Boundary Overlaps During the Professional Relationship**

After beginning work with a client, it is not at all unusual to find that your life overlaps with your clients' lives in ways you had not predicted. As the Case Example of Lin and Ginny illustrated, you and your client might find yourselves both beginning something new. You might also discover that you know the same people, attend the same church, or have other connections that predate your professional relationship. Finally, you might find that your counseling relationship itself has generated potential nonprofessional contact. Each of these deserves informed consent airtime.

**Beginning something new**

Beginning something new together can be unsettling for client and professional alike. Starting lessons, joining a club, attending a class, going on a retreat, doing volunteer work—the potential list is endless. At the very least, these new shared environments should be discussed and explored at the professional's initiative. Most likely, when possible, it will be best for the therapist to postpone or minimize involvement in the new environment. However, that is not always the case—or even possible. It depends on the size of the new group, the level of direct contact, the level of intimacy required in the new endeavor, and both parties' level of self- consciousness about the contact and the new activity.

**Current overlapping connections**

In the most careful and thorough intake process, it is not possible to unearth all possible overlapping relationships that might exist between mental health professionals and new clients. Even in large urban areas, the chances of people knowing the same people or belonging to the same organizations is surprisingly high. Discovering connections you did not know you had with clients can present interesting challenges. These connections might come to light in the overlapping setting, or in the context of the material your client is sharing.

Here are some quotes from real- life situations:

1. —“Oh, guess what,” says your client. “It turns out my husband is your husband's supervisor at work. Isn't that something?”
2. —“Well, Hell- ll- o,” says your wide- eyed client as you exit the shower. “I didn't know you belonged to this athletic club.”
3. —“I saw you at Red Robin last week,” says your client. “It looked like you were with Cheryl. Are you two dating? She's my cousin's best friend. And I can tell you all about her.”

Each of these declarations calls for careful, professional attention. The counselor needs to reassure the client that confidentiality boundaries will hold, and explore the feelings associated with these connections. It is possible to consult with your client, or with colleagues or supervisors, as to how to minimize the contact and uncomfortable sense of exposure that might come with these overlapping boundaries.

**Counseling- related nonprofessional interactions**

As the ACA code notes, there are interactions that might stretch or extend the professional relationship boundaries (R. Sommers- Flanagan, Elliott, & Sommers- Flanagan, 1998). The code explains the need to process and obtain informed consent for these interactions ahead of time and to only consider them if they are potentially beneficial to the client. The examples given suggest a humane extension of relationship, such as hospital visits, or attending meaningful ceremonies in the lives of clients.

These types of nonprofessional interactions may seem harmless and simple, but there are ethical and clinical ramifications to consider. When clients ask their counselors to attend weddings, visit them in the hospital, or come to their championship tennis match, they are asking for time, connection, and special attention. These are life activities usually attended by friends and family. Professional helpers are neither. The careful deliberation called for in the ACA code necessitates taking time to respond, and involving the client in thinking about the meaning of the request and how the potential outcomes might feel. There is no easy or correct response, other than careful and interactive consideration (Glass, 2003).

Memberships in professional and community organizations are also potential nonprofessional interactions. It is hard to imagine how the professional helper's membership in a church, political party, or professional organization would be directly beneficial to the client. On the other hand, such multiple roles likely pose little to no harm to the client, if properly acknowledged and considered.

**Postprofessional Relationship Boundary Considerations**

There are many factors to consider in postcounseling or posttherapy relationships. Transference dynamics and all the other unique attributes of the professional relationship argue against such later relationships, or at least offer grounds for caution. We will discuss sexual relationships in later paragraphs, but other than sexual relationships, the codes do not directly prohibit postcounseling friendships, teaching, or business relationships. However, in our opinion, and that of others (T. Remley & Herlihy, 2005), counselors should not readily engage in postcounseling relationships. Here are several reasons:

* The good work done in counseling can be damaged by later friendships that reveal shortcomings in the counselor or have other relational things go wrong (Kitchener, 2000).
* Clients may need to return to counseling, and may much prefer to see the same counselor. If the counselor has become a friend, this option would not be ethical (Vasquez, 1991).
* The power differential, and the responsibilities associated with it, never really ends, even though therapy ends. In a recent study, the vast majority of mental health professionals surveyed indicated they believed in client perpetuity, or “Once a client, always a client” (Lamb, Catanzaro, & Moorman, 2004).
* Professionals who entertain the idea of postcounseling relationships with clients may unconsciously treat clients differently, depending on their potential as later friends or business associates.

**PRACTICES AND TECHNIQUES WITH BOUNDARY IMPLICATIONS**

Your theoretical orientation, setting, and the type of therapy or helping techniques you use will define a large portion of your counseling boundaries (Glass, 2003; J. Sommers-Flanagan & Sommers- Flanagan, 2004b). Your usual and customary practices should be well defined and available to clients in your paperwork. In general, treat clients equally, and when you decide to extend or change one of your customary practices, document your therapeutic reasons for doing so. This creates your own standard of practice, and a set of boundaries that define your work. There are, however, certain practices and/or techniques that fall in boundary gray areas (Glass, 2003), and should be carefully considered. We discuss some of these in the following paragraphs.

**Gift Giving and Receiving**

One potential interaction that has boundary challenges within many professional relationships is that of gift giving. More commonly, counselors must address gifts offered by clients, but occasionally, counselors will experience an urge to give clients a gift. Either direction, the gift and the urge must be consciously considered and usually processed with the client (Smolar, 2002). Many mental health professionals avoid this potential problem by stating in their intake paperwork and/or informed consent process that they cannot accept gifts. Clients may or may not pay attention to this statement, but if they bring a gift, the counselor can gently remind them of the policy.

Some counselors accept small gifts. The usual monetary cutoff suggested is $10.00, which comes from research done in the late 1980s (Borys & Pope, 1989). Perhaps, allowing for inflation, that figure could now be $20.00. The point is that some professionals are comfortable accepting small gifts from clients and it would be difficult to prove that, as a general practice, this harms clients. What might be more important to consider is the nature and meaning of the gift (Smolar, 2002). While not expensive, two long- stemmed red roses probably carry a different message than a jar of homemade jelly. The meaning behind each gift needs to be explored in the context of the therapeutic relationship.

Large gifts are more problematic. In the research previously cited, 90% of the respondents thought that accepting gifts valued at $50.00 or more was ethically questionable (Borys & Pope, 1989). This consensus underscores the significance of this seemingly simple human ritual—gift giving. Accepting a large gift has the following ethical ramifications:

* The gift could be a wonderful, tasteful gift you enjoy a great deal. This could lead to a slight loss of objectivity. Despite yourself, you might find yourself favoring the gift- giving client over others, or worrying more about upsetting or offending the gift- giving client than doing good work.
* The gift could be odd, offensive, or something you cannot use. This could lead to either dishonest behavior on your part, as you assure your client you like and appreciate the gift, or to hurt feelings if you reject it or fail to use it.
* The client could expect you to display the gift. This could easily interfere with your office décor, and could lead to issues in confidentiality if you were asked where you got the gift.
* The gift could involve travel or attending an event. This creates a quasi- social relationship, should your client plan to attend with you, or something social that connects you and your client in future conversations.
* If things take a difficult turn in your counseling relationship, the client might request you give back the gift or reimburse the costs.

Given the complexities and future potential temptations, it is easier to have a consistent no- gift policy. However, it may certainly be ethical to accept small gifts, especially when refusing to do so would harm your therapeutic relationship, and in fact, the process can provide opportunities for insight and growth (Hahn, 1998). Deciding when and/or if to accept a gift requires clinical wisdom and maturity. It is a great topic for ongoing discussions with colleagues and supervisors.

Children present a special challenge in the gift- giving arena. The gifts they offer are often small, homemade, and very meaningful. It is possible to develop practices that allow for these gifts to be received and honored. Counselors might explain to children that they display gifts and artwork for one month, sort of like museums do. At the end of the month, the child can have the gift or artwork back, or the counselor will put it away in a special place, so that there is room for other “displays.” Counselors can also explain that they do not tell other people who did the art or gave the gift because some people like to have their counseling stay private. This type of solution will vary, depending on setting, theoretical orientation, school or agency policies, and your own personality and comfort levels.

Sometimes, mental health practitioners will feel a need or wish to give their clients gifts. If invited to a ceremonial event in the client's life, or if a young client makes the counselor acutely aware of an upcoming birthday, the pull can be quite strong. One concern in choosing to give a small gift, or sending a card, is the insinuated intimacy, or special status, of the client. Gift giving by counselors is not a common practice, so it is a boundary extension, or break, in usual practices. When working with children and teens, set a policy ahead of time for how to handle the inevitable requests to buy fruit, cookies, trinkets, and other fundraising items.

Another concern in gift giving is the break in impartiality. Are you willing to give gifts to all clients in similar circumstances? As we mentioned in [Chapter 2](https://jigsaw.vitalsource.com/books/9781119087922/epub/OPS/c02.xhtml), impartiality is an important dimension in certain moral philosophies (Rachels, 1986). For instance, from a deontological perspective, you might consider it your duty to be fair and impartial. From a consequentialist perspective, you would need to consider your actions in terms of the greatest good for the greatest number.

The complexities of gift giving and the culturally varied meanings provide an example of how ethical concerns and clinical concerns are so deeply interrelated. Even if you ultimately decide you cannot accept a gift offered by a client, there are many possible issues to explore together as part of the therapeutic relationship.

**Deepening Diversity 7.1**

**Gift Giving and Culture**

Gift giving has culturally imbued meanings to consider. For many American Indian tribes, gifts are given as a sign of honor, and the act of giving is a sacred privilege (Herring, 1996). There are gifting ceremonies that involve many rituals and expectations for both the gift givers and the gift receivers. In Asian cultures, gifts can signal respect and express gratitude (Cuellar & Paniagua, 2000). Increased understanding and important clinical work can be accomplished as the cultural meaning of gifts is explored with clients. Obviously, gift giving and receiving from both professional and cultural viewpoints offers significant food for thought.

Families, as mini- cultures, have gift- giving rituals that may date back to cultural practices so old that the family no longer even realizes the connection. Consider the role of gifts in your family and community. What occasions call for gifts? What is being expressed? Are gifts valued for their monetary worth? Their symbolic message? Do the gifts involve services, homemade items, or other personalized attributes? What happens if a gift is rejected or unappreciated?

**Self- Disclosure**

Self- disclosure is an expected social interaction in the dominant culture in the United States. Sometimes, new counselors have a difficult time calibrating self- disclosure. It can feel imbalanced or unfair to listen as a client discloses, but then to offer few disclosures in return. Beginning professional helpers often experience an urge to tell their clients about similar life experiences, reactions, or common tastes, such as favorite teams or local restaurants. Even more difficult are direct questions from an inquisitive or intrusive client. The ability to respond with grace and sensitivity to personal questions, while at the same time not necessarily answering them, is an important skill to develop (A. Benjamin, 1981).

Certainly, you can choose to answer certain personal questions, but just like gift giving, exploring the client's urge to ask such questions might hold rich clinical material. A rule to keep in mind when asked questions is explore first, then answer if appropriate (J. Sommers- Flanagan & Sommers- Flanagan, 1989). On some occasions, it is acceptable to answer the questions first and then explore afterward, if needed. A basic rule of thumb for self- disclosure is that it should always be in the service of the client. In other words, in the context of a professional relationship, self- disclosure is a professional activity that could seem quite personal to a client, and ultimately create confusion about boundaries (Pipes, Holstein, & Aguiree, 2005).

**Case Example**

Melodee was an intern working with a socially anxious young man named Will. During his third session, Will talked about how he longed for the courage to ask out someone as nice as Melodee. He paused, looked down, rubbed his hands on his pants, blushed, and said, “I guess you're probably married, huh? I bet you married someone good looking. Someone smart? Am I right?”

Melodee felt a rush of gratitude for the role- plays that had prepared her for such an emotionally charged direct question.

“Will,” she said. “I can tell that it took real courage for you to ask me that. And I take it as a compliment, too. Could you talk just a little bit about how you got the courage to bring this up and to give me that nice compliment?”

Will looked a little confused, but smiled. “Yeah. I can talk about that, but are you going to answer me?”

Melodee smiled too. “Sure, I will, but let's talk about the question first, if that's okay. The work we're both here to do is for you. It's a lot more important to figure out where that courage came from so you can use it again soon. If we get distracted talking about my personal life, we may lose this chance.”

Self- disclosure also has cultural variation in efficacy and appropriateness (Kim et al., 2003; Simi & Mahalik, 1997). In certain American Indian tribes, silence signals respect. However, self- disclosure, especially when it provides common ground, can help increase trust and connection (D. Wetsit, personal communication, November, 1993).

**Considerations about Touch**

Touching, like gift giving, can seem deceptively simple and innocent. Most of us distinguish between nonerotic touch (handshakes, pats on the arm, comforting hugs) and erotic touch (sensual hugs, stroking, and kisses intended to communicate sexual interest or cause sexual arousal). Or at least we think we do. But touch is not something that can easily be dichotomized. Lovers know that even the slightest brush of arm to arm can be arousing. Trusted family members or close friends can engage in full- body hugs, pats to the fanny, farewell kisses, and other forms of intimate touch that carry no sexual content for either party. And in the event of a big win, team players practically maul each other—lots of emotion but, at least to the observing sports fan, little erotic intention. To further complicate things, nonerotic touch can become erotic in certain circumstances, and touch intended to be erotic can fall far short of its goal in others. Examples of this from your own lives might make for a lively class discussion. Ask your professor to take the lead in this self- disclosure.

Rather than attempting to define touch as either erotic or nonerotic, it is probably more accurate to think of touch as a powerful form of communication with comfort and erotic potential. Touch patterns and rules are also gendered. In our culture, touch also carries nonverbal signals of power and hierarchy. Women tend to touch in order to offer comfort, and men in order to signal power (Woods, 2004).

**ASSESSING POTENTIAL BENEFIT AND HARM**

Mental health professionals have long been charged with assessing potential harm to clients when boundary extensions, breaks, or multiple roles are being considered. The new ACA wording changes the focus to an assessment of potential benefit—but in reality, both harm and benefit must be considered. This consideration must take into account the counselor as well as the client. Karen Kitchener (2000) offered guidance for assessing the potential harm in overlapping roles. She noted that the differences in obligations and expectations between roles can cause clients confusion, misunderstanding, and even anger. As the potential for conflicts of interest increases, so does the potential for difficulties. Professionals can be tempted to place their own needs ahead of the client's needs.

More recently, in the article entitled Managing risk when contemplating multiple relationships, Younggren and Gottlieb (2004) offer the following questions to consider:

1. Is entering into a relationship in addition to the professional one necessary, or should I avoid it?
2. Can the dual relationship potentially cause harm to the patient?
3. If harm seems unlikely or avoidable, would the additional relationship prove beneficial?
4. Is there a risk that the dual relationship could disrupt the therapeutic relationship?
5. Can I evaluate this matter objectively? (pp.256–57)

It is not possible to numerically quantify the harm or benefit to assess when counselors consider engaging in multiple roles or nonprofessional interactions with their clients. Gottlieb (1993) presented a decision- making model that included three aspects of the relationship: the amount of power or personal influence involved in the relationship, the duration expected in the relationship, and whether the proposed professional relationship would likely terminate conclusively or intermittently (with the client perhaps needing to return for additional assistance over time). As you face multiple role decisions, we suggest using a dimensional approach. We describe such an approach in Applications 7.2. By actually filling in the quadrant and assigning relative values to the differing dimensions, you can more closely examine the potentials.

It may seem self- serving or even unethical to consider professional benefit and harm in relation to client benefit or harm. However, to be effective and compassionate professionals, all kinds of helpers need to take care of themselves, and do not make decisions that put themselves or their families in awkward or dangerous situations. If they did, ultimately, the welfare of their clients would be in jeopardy. This is why self- care is closely related to providing ethical client care, especially in rural areas, with the demands discussed in the following section (Nickel, 2004).

There is a range of views on what constitutes a counseling relationship boundary violation. Some writers and practitioners believe the profession itself has become overly rigid about boundaries, arguing that artificial barricades between professionals and clients can impede or even harm therapeutic relationship connections (Fay, 2002; Lazarus & Zur, 2002). For example, Lazarus has long argued that activities such as playing tennis or having dinner with a client can have therapeutic benefit, and that occasional human connections such as catching a ride will not necessarily do any harm (Lazarus, 1994).

Generally, theories of counseling or psychotherapy that emphasize longer and deeper treatment protocols have tighter, more rigid boundaries. This is partly due to the importance of working with transference in longer- term work and partly because of deeper and more personal disclosures associated with long- term therapy (Glass, 2003). On the other hand, counselors working primarily with children might approach boundaries with a slightly looser frame (J. Sommers- Flanagan & Sommers- Flanagan, 1997; Thomp son & Rudolph, 2000). And remember, human relationship boundaries of all sorts are culturally determined. Therefore, culture will play a central role in the subjective experiences of clients and professionals.

**Applications 7.2**

**Analyzing Multiple Roles or Nonprofessional Interactions**

Create a four- square grid, similar to the one pictured. Within your grid, list all possible outcomes that might result from the role or interaction under consideration. Place every outcome you can think of in the appropriate box, and assign each one a rating of neutral, slightly, or very. Then give each entry a second rating of not likely to happen, slightly likely to happen, or very likely to happen. If your answer to Younggren and Gottlieb's question number 5 (can I evaluate this objectively?) is no or even maybe, then involve a supervisor or colleague in this process from the onset.

|  |  |
| --- | --- |
| Outcomes with Potential Client Harm | Outcomes with Potential Client Benefit |
| (Rate each as to how likely it is to occur) | (Rate each as to how likely it is to occur) |
| (Rate each with how damaging it might be) | (Rate each with how damaging it might be) |
| Outcomes with Potential Harm to | Outcomes with Potential Professional |
| the Professional | Benefit |
| (Rate each as to how likely it is to occur) | (Rate each as to how likely it is to occur) |
| (Rate each with how damaging it might be) | (Rate each with how damaging it might be) |

For practice, with classmates or on your own, try using this system to consider the following:

1. Chan is contemplating providing counseling to a teenage boy, Milo, who plays on his son, Ben's, soccer team. The parents have heard about Chan's great work with underachieving teen boys, and they very much want Chan to see their son. Milo and Ben know each other, but are not good friends. There are 18 boys on the team. This is Milo's second year, but Ben's third. Both families live in the suburbs of a town of 100,000, with similar cultural backgrounds.
2. Tamika is working with 38- year- old Shari who is suffering from anxiety and mild depression. During the time she is working with Tamika, Shari's mother was killed in a tragic car wreck. Although the funeral was small and private, Shari's mother was an active member of many community organizations, so there is going to be a memorial service. Shari asks Tamika if she would like to attend. Tamika lives in an Asian neighborhood, married to a man from China. Shari is African- American.

**LITTLE COMMUNITIES, BIG BOUNDARIES?**

*In little towns, lives roll along so close to one another; loves and hates beat about, their wings almost touching.*

—Willa Cather

No chapter on boundaries would be complete (especially by authors residing in Montana, who've lived in upstate New York, and have colleagues in tiny towns in Mississippi, Pennsylvania, Iowa, and the Dakotas) without considering the important dynamics of smaller, more intimate communities. Although small towns and rural communities are sometimes romanticized in literature and the media, they are just as often maligned for their damaging limits. The Reverend Vernon C. Mcgee once said, “Man made the city, God made the country, but the devil made the small town” (2004, p.48).

The realities of rural America are that depression, alcoholism, cancer, heart disease, diabetes, and arthritis all occur at higher rates in rural communities than in urban communities (Thurston- Hicks, Paine, & Hollifield, 1998; Wagenfeld, Murray, Mohatt, & DeBruyn, 1997). The need for competent mental health counseling services is acute, and the problems inherent in rural work, whether ongoing or emergent, are complex (Jackson & Cook, 1999). Simply maintaining confidentiality becomes nearly impossible when everyone in town knows who is parked outside the counseling office, the cashiers at the bank know the people writing the checks to pay the fees, office staff are related to the clients, and so on. A number of studies have indicated that those working with rural patients and clients believe that these clients worry about confidentiality and privacy, and are less likely to talk openly about all areas of their lives (Ullom- Minnich & Kallail, 1993; Teddy D. Warner et al., 2005).

Of course, confidentiality isn't the only ethical issue. Multiple relationships between counselors and their clients are inevitable, as are overlapping relationships that involve family members of counselors and clients. An ethical indictment of all multiple roles is unrealistic and harmful to all concerned (Brownlee, 1996). In one small study, rural and frontier professionals expressed a clear need for ethical training specifically tailored to nonurban settings (Roberts, Warner, & Hammond, 2005).

**Case Example**

While working with a 15- year- old boy, I (JSF) found myself with several rural boundary related decisions. The two most memorable were, (a) the fact that the boy went to the same school as my daughter, and (b) the boy's need to have a comforting adult accompany him to three stressful court hearings. Although other professionals could have made different decisions about these boundary issues, I chose to handle them in the following ways:

1. I informed the boy that my daughter attended his school and assured him that I did not talk to her about my clients. I explained to him that he could make his own choices about having contact with her at school or during social activities after school. I told him that I specifically did not want to hear about anything she might say or do at school or during social activities outside school.
2. I told the boy that if he wanted me to, I would attend the court hearings as a support person, if he informed me of the day and time at least 1 week in advance.

Besides rural communities, there are other forms of small, connected communities of people, such as the gay/lesbian/transgendered/bisexual community (Kessler & Waehler, 2005), military bases, spiritual or religious communities, athletes, academics, and cultural enclaves. Membership in these communities can actually increase trust among the members (Lazarus, 2005; Robinson, 2003) when they interact professionally, but the roles and boundary negotiations require extra professional attention and care. Professional helpers who share membership in small communities with their clients have more complex boundary considerations than those who do not share such memberships. Unidimensional declarations such as “client welfare trumps all other considerations” must be widened and contextualized, but not ignored. Of course, client welfare must always be considered, but by using the grid previously depicted in this chapter, it might be possible to work out a satisfactory balance between client needs and professional contingencies. For example, the ideal situation might be for your client, who happens to be the only pediatrician in town, not to meet or offer medical care to your child. However, assuming your child needs this care and there are no realistic alternatives, you can work clinically to reduce potential discomfort for your client while not necessarily being unethical in seeking medical care for your child.

**ROMANCE, SEX, LOVE, AND LUST**

We have grown weary preaching that sex with clients, former clients, and any person in a close relationship with a client is prohibited. There is not a therapist in the country that does not know this ethical restriction, yet it still happens with alarming frequency. (Bernstein & Hartsell, 2000, p.115)

We share the weariness expressed in the previous quote. When is it appropriate to consider a sexual relationship with a client? (Fill in the blank:) \_\_\_\_\_

We hope you can fill in the blank accurately. But what if the client is a virgin, who is dying, and wants to experience sex just once, and only trusts you? But what if you have fallen in love? But what if this is the first person you have ever, ever felt this way about? But what if you are willing to give up your career and become a baker? But what if you terminate the relationship, and then he/she is not your client? Maybe you can think of other “but what ifs.” The answer remains the same. Never. It is never ethically permissible, by any codes, in any helping relationships, to initiate or participate in a romantic or sexual relationship with a current client.

**ACA *Code of Ethics*e**

1. **A.5.a Current Clients**

Sexual or romantic counselor- client interactions or relationships with current clients, their romantic partners, or their family members are prohibited.

**NASW *Code of Ethics***

1. **1.09 Sexual Relationships**

Social worker should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced.

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.

**APA *Ethical Principles***

1. **10.05 Sexual Intimacies with Current Therapy Clients/Patients**  Psychologists do not engage in sexual intimacies with current therapy clients/patients.
2. **10.06 Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients**  Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

Unfortunately, this code clarity and unanimity does not mean such interactions are rare. Various self- report studies, dating from 1977 to 1995, indicate that approximately 7% of male mental health professionals and 1.6% of female mental health professionals admitted to having sexual relations with current or former clients (T. Remley & Herlihy, 2005).

Why do we have these mandates? All the cautions we offered in the previous portion of this chapter regarding multiple relationships are magnified a hundredfold when sexual attraction and arousal are part of the equation. This multiple role has enormous potential for client harm. The following list details the categories of client damage. The list was summarized by Karen Kitchener (2000) from the work of Ken Pope (1988).

* Clients experience ambivalence about the professional. They feel attached and afraid of losing the counselor, but also have feelings of rage and other negative feelings.
* Clients experience guilt. They worry that they are somehow responsible.
* Clients feel empty, isolated, and estranged from others. They feel unworthy of other relationships.
* Clients experience confusion about their sexuality, which may lead to other abusive or traumatic sexual encounters.
* Clients have an impaired ability to trust. Their counselor violated their trust at a most vulnerable time.
* Clients experience difficulty sorting out boundaries. They lose clarity about their own needs and their own role in intimate relationships.
* Clients become depressed and/or emotionally volatile and labile due to being overwhelmed by the situation.
* Clients report suppressing their rage at being victimized.
* Clients report increased suicidal and self- destructive feelings.
* Clients have symptoms such as flashbacks, nightmares, and unbidden images in their minds.

The power differential is immutable and cannot be wished away, defined away, or diminished. The professional is always the party responsible for keeping this boundary absolutely intact. The harm done by sexual relations with clients often extends beyond the client to other family members as well. Unbelievable as it may seem, marriage therapists on occasion choose to begin an affair with one member of the couple they are seeing. Understandably, the other member sometimes pursues legal action (Alexander v. The Superior Court of Los Angeles, 2002; Stevenson v. Johnson 32 Va. Cir. 157, 1993).

With laws and practices so firmly established, choosing to become involved sexually with a client also has enormous potential for harm to the professional. Criminal charges (Bernstein & Hartsell, 2004), financial ruin from civil suits (Jorgenson, 1995), and the loss of one's career are all very real possibilities for the professional who engages in sexual contact with a client.

Given the clarity of this edict, and the obvious potential harm, why does this ethical violation continue to occur? Of course, this cannot be answered definitively. However, the pioneering and ongoing research by Ken Pope (1990b) and colleagues has helped paint a picture of the circumstances and rationalizations that are related to this offense. These include therapists who use intimidation or threats, who exploit extremely needy clients, or who allow their own wishes and needs to dominate. There are still counselors who claim that having sex with a client is a valid part of the treatment, or that it is permissible to have sex with the client between sessions, or out of the office setting (Somer & Saadon, 1999).

Some sexually offending mental health professionals are burned- out, lonely, isolated, and/or inadequate (Shirley Emerson & Markos, 1996; D.S. Smith & Fitzpatrick, 1995). Others have serious antisocial or narcissistic personality disorders, with general feelings of entitlement and little to no empathy for their victims (Scheoner & Gonsiorek, 1988). However, there are also offenders who are naïve or badly trained. They typically engage in other forms of boundary violations, such as hugging, social contact, or inappropriate and excessive self- disclosure before slipping into full- blown sexual relationships (Lamb & Catanzaro, 1998). Kaplan (2001) notes that a number of studies suggest that a significant number of therapists who have sexual relationships are white, male, private practitioners who are either divorced or going through a divorce.

Ignorance of ethics and/or of one's own sexual being and needs are not excuses for sexual misconduct. Education and overall character development play an important part in humans achieving healthy sexual lives and making mature sexual decisions (Krebs & Denton, 2005). Often, graduate students in the helping professions do not find sex terribly easy to discuss. However, graduate school is an excellent time to learn more about human sexuality and your own areas of ignorance, fear, need, vulnerability, and longing. People often seek counseling because of disappointments in intimate relationships. They may need to tell you about these disappointments, and their needs, fears, or fantasies. The more you know about sex and yourself as a sexual being, the less likely you will be to react with embarrassment, shyness, curiosity, or indignation. More importantly, the less likely you might be to act out sexually with a client—thus avoiding a potentially disastrous mistake for all involved.

The professional helping relationship itself has many potentially erotic aspects. Being listened to attentively and caringly and listening deeply to another can elicit intense feelings of connection. For some, the power differential itself might play a role in erotic attraction. There are plenty of famous sayings about the attractiveness of forbidden fruit, and Hollywood seems unable to resist producing movies with the main theme revolving around the seductive client, the seductive counselor, or the inevitability of their “love.”

Clients can be intriguing, beguiling, vulnerable, seductive, incredibly erotic creatures. Professionals are human beings. They will, on occasion, be sexually attracted to a client. This is not unethical. It is simply human. It's what they do when they notice the attraction that is of ethical concern. We offer the following suggestions for ethically handling sexual attraction.

* Do not panic. You can sort this out with clinical and ethical wisdom.
* Do not tell your client you are attracted to him/her.
* Call supervisors and/or colleagues and seek their input right away. Do not reveal the identity of your client. Describe your client and your work enough to get a sense of the client's diagnostic categories, needs, and role in the attraction you are experiencing. Discuss how reciprocal you think the attraction is, and how long it has been there.
* Do an inventory of your own intimacy and sexual needs. Is this a signal that you've not been attending to this area of your life? If you are in a committed romantic relationship, it may be time for some serious talking, or other forms of relationship enhancement or repair.
* With supervision, decide if you can safely continue to see the client while you do the consulting or counseling work you need to do. If the attraction does not seem to be growing, or out of control, focus on rejuvenating existing mutual relationships, and take care of yourself in other ways. You may not need to refer the client. You may be able to work through this set of feelings with the help of supervision, collegial support, and/or therapy.
* If you cannot continue to see the client due to continued sexual attraction, review the case very carefully with a supervisor, and come up with a plan for referring the client that will cause the least possible damage. At the very most, reveal to the client only that you have some personal needs and must refer some of your clients so that you can attend to these needs. Do not burden your client with any more detail than this.
* If you transfer or refer the client, do not allow or seek any further contact.
* In your own counseling, or in other effective venues, do the extremely important work you need to do to understand how this attraction happened.

**SEX BEFORE OR AFTER?**

After firmly establishing the notion that sexual interactions with current clients should be forbidden, professional ethics codes began wrestling with questions surrounding the time of active counseling. Could a mental health professional ever ethically treat an ex- lover? Would it be permissible to date a former client? If so, exactly how former should the client be? Students often find it surprising that every step of the way in this intimacy- restricting aspect of ethical codes, the limits have been hotly debated and protested.

At present, most codes prohibit counseling someone with whom you have had a sexual relationship. It is far too likely that objectivity will be impossible to achieve. Also, most codes strongly discourage sexual relationships with former clients, and forbid it for a certain number of years. APA lists 2 years; the Canadian Counselling Association, 3; and the ACA code changed from a 2 year prohibition to 5 years in the latest edition. The NASW code states “Social workers do not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client.”

There is consensus among the writers of codes that sex with former clients is highly questionable, and must be scrutinized very closely for any possible exploitation, coercion, or manipulation. Though infrequent, there are court cases wherein counselors who became sexually involved with former clients were sued for negligence by the former client when the relationship went bad (Ludka v. O'Brien- Brick 1995 Wisc. App. 1670, 1995).

**Pause for Reflection**

*Sexual attraction is a biologically based phenomenon over which we arguably have little control. Sexual activity among humans, on the other hand, is a highly ritualized, meaning- imbued, culturally regulated interaction. How do you anticipate your own values, needs, hopes, and fears to influence you when clients express sexual attraction to you? When you experience sexual attraction to a client?*

**CHAPTER WRAP- UP**

African- American poet, Gwendolyn Brooks, wrote “We are each other's harvest; we are each other's business; we are each other's magnitude and bond” (G. Brooks, 1970, p.19). The roles we have in each other's lives, and the borders we create around those roles, are central to our most basic senses of meaning and safety. In one of my clinical settings, I (RSF) interviewed a very disturbed young mother and her 4- year- old daughter, each with the same first, middle, and last name. “Sometimes, I don't know if she's hungry or I'm hungry,” the mom said. “So I bake a cake.”

The human dance between dependence and independence, between enmeshed and disengaged, is a fascinating, complicated dance. Human boundaries vary based on culture, community, age, and individual style. This chapter covered how they vary based on the definition of the relationship. Professional counseling, consulting, teaching, helping, or supervising relationships have inherent power differentials and, therefore, the professional has boundary- keeping responsibilities of great consequence and complexity.