ETHICAL GUIDELINES REGARDING NONSEXUAL DUAL RELATIONSHIPS:
RESPONDING TO THE NEEDS OF PSYCHOLOGISTS WORKING IN RURAL AREAS
AND SMALL COMMUNITIES

BY

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ABSTRACT

This project focuses on ethical issues faced by psychologists practicing in rural areas and small communities with regards to entering into and managing nonsexual dual role relationships. Mental health professionals often face ethical dilemmas in their attempts to meet the needs of clients while maintaining the clearly defined boundaries specified by provincial and national governing bodies. This project offers research based ethical guidelines intended to support mental health professionals working in rural areas and small communities by setting forth consistent guiding principles in order to maintain constant and reliable ethical standards of practice.
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CHAPTER I

Introduction

Much of the literature regarding nonsexual dual relationships suggests that for psychologists practicing in rural areas and small communities, such interactions are unavoidable (Ebert, 1997; Moleski & Kiselica, 2005; Perkins, Hudson, Gray, & Stewart, 1998; Reamer, 2003; Schank & Skovholt, 1997; Scopelliti et al., 2004; Younggren, 2002; Zur, 2001). Furthermore, while research suggests that psychologists find dual relationships to be a significant source of stress (Pope & Vetter, 1992), not only is there a notable lack of clear guidelines for psychologists encountering nonsexual dual relationships, but those guidelines that do exist are biased against psychologists practicing in rural areas and small communities (Barbopoulos & Clark, 2003; Ebert, 1997; Helbok, 2003; Prilleltensky, Rossiter, & Walsh-Bowers, 1996; Roberts, Battaglia, & Epstein, 1999; Rossiter, Walsh-Bowers, & Prilleltensky, 1996; Schank & Skovholt, 1997). The underlying aim of this project is to develop guidelines that are sensitive and responsive to the complex nature of rural and small community practice with specific regards to entering into and managing nonsexual dual relationships. Based on the information gathered in the literature review, it is the intent of the writer to put forth ethical guidelines that are relevant and applicable to those who will utilize them.

In order to develop a clear understanding of the challenges facing psychologists practicing in rural and small communities particular to entering into and managing dual relationships, it is important to review the literature regarding the development and implementation of codes of ethics, the concept of boundaries, the perception of nonsexual dual relationships, and existing decision-making models, to discuss these in the context of
mental health practice in rural areas and small communities and to clearly define the terms “rural” and “small communities” as they are used within this paper. From this review and discussion, suggestions will be made regarding ethical guidelines to be adhered to by psychologists serving clients in rural areas and small communities in order to ensure the consistent utilization of common practice standards, thereby protecting both professionals and those seeking their services. Finally, there will be discussion of future steps that can be taken to assist psychologists practicing in rural areas and small communities to better manage the challenges of dual relationships.
CHAPTER II

Research Method

The references included in this literature review were obtained from a variety of sources. In order to complete the literature review an internet-driven literature search was undertaken using the Google search engine, EBSCOhost databases, as well as the OVID databases, which include Journals @ OVID Full Text, EMBASE, PsycINFO, Your Journals @ OVID, and PsychBOOKS. Searches were limited by year of publication to include material published between 1990 and 2008. The terms searched included “codes of ethics”, “ethical codes”, “ethical dilemmas”, “boundaries”, “boundary crossings”, “boundary violations”, “dual relationships”, “multiple relationships”, “rural mental health”, and “rural psychology”. The articles and documents thus accessed were utilized to summarize the current understanding of ethical guidelines, nonsexual dual role relationships, and the links between the two topic areas.
CHAPTER III

Literature Review

Introduction

This literature review examines research and articles dealing with the concepts of ethics, boundaries, and dual role relationships. The review will provide a comprehensive understanding of the development and implementation of existing ethical guidelines, the definition of rural and small communities, boundary crossings, boundary violations, and nonsexual dual relationships, the types of nonsexual dual relationships encountered by psychologists working in rural areas and small communities, and informal strategies utilized to manage such relationships.

It is necessary to have a clear understanding of the values, morals, and practices of organizational members in order to make available ethical guidelines that are relevant to those who are expected to abide by them. Prilleltensky et al. (1996) clearly outlined the connection between the values of the professional and the outcome of the therapeutic process: the values held by the individual professional act as guidelines that result in moral and ethical actions; those ethical actions then lead to positive outcomes for the clients. It is important to take into account the values of the members of an organization because the same basic ethical principles can be interpreted differently depending on an individual’s values. By developing guidelines that are closely tied to the beliefs, values, and experiences of the majority of rural psychologists, there is a greater likelihood that those guidelines will be adopted and internalized, thereby increasing the potential for positive client experiences.

Boundaries can be seen as essential to the healthy functioning of relationships between people, including the professional relationship between psychologists and clients.
Professional boundaries, which can be defined as “a psychological space or distance between individuals, one that is used to emphasize the clinician’s stance of anonymity, neutrality and objectivity” (Scopelliti et al., 2004, p. 955), give clients a sense of safety (Smith & Fitzpatrick, 1995). This sense of safety contributes to the development of trust, a key element in the creation of a strong working alliance. Due to the nature of rural and small community practice, psychologists working in these areas deal with more boundary-related issues than urban psychologists. While there are a substantial number of Canadians living in rural areas, there are a comparatively low number of psychologists. Statistics compiled by Bazana (1999) show that in urban areas there is 1 psychologist for every 2195 people, while in rural areas there is 1 psychologist for every 9619 people. With significantly fewer psychologists per capita, rural psychologists face an increased likelihood of encountering nonsexual dual relationships and require supportive guidelines.

When there is a blurring of personal and professional boundaries, dual relationships develop. According to Pope (1991), a dual relationship exists when the professional has a therapeutic relationship with a client as well as a significantly different relationship, such as social, financial, or professional role with that client. While some believe that all nonsexual dual relationships are harmful to the professional-client relationship and should be avoided (Moleski & Kiselica, 2005; Nigro, 2004; Pope, 1991; Reilly, 2003; Scopelliti et al., 2004), other professionals believe that such interactions can have a positive impact on the working alliance, with the potential to benefit the client (Barnett & Yutrzenka, 1994; Dineen, 2002; Ebert, 1997; Fay, 2002; Guthmann & Sandberg, 2002; Reamer, 2003; Scheflin, 2002; Williams, 2002; Younggren, 2002; Zur, 2001). As a result, nonsexual dual relationships have been further delineated as boundary crossings and boundary violations (Zur & Lazarus,
Boundary crossings are defined as beneficent and non-threatening transience of traditional psychotherapeutic boundaries, while boundary violations are defined as actions made by the psychologist that threaten the dignity of the client, negatively impact the client-counsellor relationship, and are perfidious in nature. While nonsexual dual relationships may have the potential to be harmful to clients, in rural and small community practice they are often unavoidable. The smaller the community, the fewer services available to the residents, the less able the professional is to limit contact and familiarity with residents. While a professional may feel uncomfortable in providing services to a client with whom one has a social, financial, or professional relationship, there may be no one else available to provide that service. Clearly, in some cases it is not a matter of deciding whether to be involved in nonsexual dual relationships, but how to manage them.

*Ethics, Values, and the Implementation of Codes of Ethics*

*The developmental process.* The development of ethical guidelines regarding the provision of mental health services has a relatively short history. The original creation and implementation of guidelines was reflective of the desire of psychologists to be viewed as qualified and respected experts in their field. It was believed that the existence of a code of ethics and regulatory body would convey the message that psychologists were responsible to society and therefore professional (Louw, 1997). For psychologists, the first code of ethics was completed by the American Psychological Association (APA) in the 1950s. In 1959, the Canadian Psychological Association (CPA) adopted the APA code of ethics and used it, with some updates, until 1986, when the CPA created their own code of ethics for Canadian psychologists.
In developing an understanding of codes of ethics it is important to differentiate between the roles of rules and codes of ethics. Rules are intended to define specific behaviors as acceptable or unacceptable within the constraints of society (Pettifor, 1996). The intent of codes of ethics, on the other hand, is to guide professionals in thinking and behaving in a manner that is not harmful to others and is in accordance with the values of society, the organization, and the individual. According to Pettifor, codes of ethics have the following purposes: (a) to assist groups in being identified as a profession, (b) to support and guide individuals within a profession, (c) to address the responsibilities of a profession, and d) to aid individuals within a profession in resolving ethical dilemmas.

The substructures supporting codes of ethics. In order to truly comprehend and implement a code of ethics it is important to understand the substructures that support that code. The principles that underlie a code of ethics are the values recognized by society as being important. Schwartz (1994) suggested four points regarding the origin and usefulness of values: (a) values are thought-based constructs that promote the interests of society, (b) values encourage certain actions by giving direction and affective importance to those actions, (c) values act as a measure by which actions are judged and justified, and (d) values are attained through social processes and individual experiences. In order to explore and develop a more accurate understanding of the existence of global commonalities regarding the framework and contents of values systems, Schwartz theorized that all values, regardless of country of origin, are based on ten value types - power, achievement, hedonism, stimulation, self-direction, universalism, benevolence, tradition, conformity, and security – and that these value form an interconnected field of motivations. In order to provide empirical support for his theory, Schwartz surveyed 97 individuals from 47 countries, with
the surveys being presented in the participants’ first language. The participants were asked to rate 56 values based on the ten value types. Analysis of the survey results supported the existence of a globally utilized framework of value structure based on the ten value types.

While Schwartz’ (1994) findings provide important guidelines to be considered when developing codes of ethics, it is also necessary to have a clear understanding of the values, morals, and practices of organizational members in order to make available ethical guidelines which are relevant to those who are expected to abide by them. In a qualitative study conducted by Prilleltensky, Walsh-Bowers, and Rossiter (1999) for the purpose of developing a code of ethics based on the experiences of mental health workers, these researchers found that mental health professionals identify the following values as important: (a) respect for individual’s rights, privacy, integrity and dignity, (b) responsible caring and compassion, (c) giving clients a voice and choice in decisions that affect their lives, (d) advocating on behalf of vulnerable clients, (e) utilizing approaches that are empowering and holistic, and (f) acting in the client’s best interests. Prilleltensky et al. clearly outline the connection between the values of the professional and the outcome of the therapeutic process: the values held by the individual professional act as guidelines that result in moral and ethical actions; those ethical actions then lead to positive outcomes for the clients. It is important to take into account the values of the members of an organization because the same basic ethical principles can be interpreted differently depending on an individual’s values. By adopting ethics which are closely tied to the values of the majority, an organization limits the differences in interpretation within the association. According to Pettifor (2001), not only is it necessary to assess the values that exist within an organization, but it is also important to identify existing documents that are relevant, to review and revise existing ethical guidelines,
and to delineate methods by which the organization can maintain ethical policies and manage ethical conflicts. Based on a thorough review of literature, Grojean, Resick, Dickson, and Smith (2004) believe that because individual values are acquired through a process of social analysis, they change over time. For this reason it is important that ethical policies be reviewed regularly and revised as needed.

**Implementing codes of ethics.** Implementing codes of ethics and policies can be a challenging process. Leadership plays a vital role in the introduction, promotion and internalization of ethical behaviors. Grojean et al. (2004) analysed existing literature regarding leadership and ethical values and identified seven methods leaders can employ to encourage staff to adopt and adhere to the ethical policy of an organization:

(a) use value-based leadership, (b) model desired behaviors, (c) establish clear expectations regarding ethical conduct, (d) provide staff with feedback, coaching and support regarding ethical behavior, (e) acknowledge behaviors that are in keeping with the organization’s ethical values, (f) be aware of individual differences among staff (i.e., different cultural, religious, or socioeconomic backgrounds), and (g) develop and maintain mentoring and training for leaders. (pp. 227-232)

All leaders working to establish and maintain a standard of ethical behavior within an organization need to function in a consistent manner when employing the above techniques. Clearly, the actions of leaders can be a powerful tool in communicating the desired standard of ethical behavior to organization members.

**Current codes of ethics regarding dual role relationships.** Codes of Ethics were originally developed with the intent of promoting the field of psychology, protecting clients, and protecting the professionals. Over time, Codes of Ethics have undergone permutations
based on current levels of knowledge and understanding. As the field of psychology has evolved, mental health professionals have become increasingly aware that dual or multiple relationships are often unavoidable, particularly when working in rural areas or with specialized groups of clients. Based on this increased awareness, the supervisory bodies of psychological practice have modified their codes of ethics, recognizing that dual/multiple role relationships are unavoidable and, in many cases, ethical (Zur, 2000).

The Canadian Psychological Association (CPA) *Code of Ethics for Psychologists* (2000), Principal III.33 states:

Avoid dual or multiple relationships (e.g. with clients, research participants, employees, supervisees, students, or trainees) and other situations that might present a conflict of interest or that might reduce their ability to be objective and unbiased in their determinations of what might be in the best interests of others (p. 26).

Further, the Canadian Psychological Association *Code of Ethics for Psychologists* (2000), Principal III.34 goes on to state:

Manage dual or multiple relationships that are unavoidable due to cultural norms or other circumstances in such a manner that bias, lack of objectivity, and risk of exploitation are minimized. This might include obtaining ongoing supervision or consultation for the duration of the dual or multiple relationship, or involving a third party in obtaining consent (e.g., approaching a client or employee about becoming a research participant (p. 27).

The Canadian Psychological Association *Practice Guidelines for Providers of Psychological Services* (2001b) states:
Psychologists avoid dual relationships with clients and/or relationships that might impair their professional judgement or increase the risk of client exploitation.

Examples of dual relationships include treating employees, supervisors, or close friends or relatives. Sexual relations with clients are prohibited. (p. 9).

The Canadian Psychological Association Guidelines for Psychological Practice with Women (2007a) states:

Evaluate the meaning of overlapping relationships in conjunction with clients. When dual/multiple and overlapping relationships are unavoidable, they collaborate with clients on how to respect boundaries and avoid doing harm. (p. 9)

The Canadian Psychological Association Guidelines for Non-discriminatory Practice (2001a) states:

Evaluate the cultural meaning of dual/multiple and overlapping relationships in order to show respect, and to avoid exploitation (p. 5).

The Canadian Psychological Association Guidelines for School Psychologists (2007b) states:

It is the responsibility of psychologists to avoid dual or multiple relationships and other conflicts of interest when appropriate and possible. When such situations cannot be avoided or are inappropriate to avoid, psychologists have a responsibility to declare that they have a conflict of interest, to seek advice, and to establish safeguards to ensure that the best interests of members of the public are protected. (p. 41).

The College of Alberta Psychologists Code of Conduct (2000) Section 11 Subsection 1 states:

Psychologists shall not undertake or continue a professional relationship when they are aware or should be aware that they face a potentially harmful conflict of interest.
as a result of a current or previous psychological, familial, social, sexual, emotional, financial, supervisory, political, administrative or legal relationship with the client or a relevant person associated with or related to the client (p. 4).

The College of Alberta Psychologists *Code of Conduct* (2000) Section 11 Subsection 4 states:

Notwithstanding subsection (1), psychologists may continue a professional relationship, although a potentially harmful conflict of interest may exist, in the following exceptional circumstances:

(a) instances where appropriate professional services from another professional are not available, such as in small communities that are isolated and remote;

(b) instances in which psychologists have special attributes that may make their services particularly relevant, such as being a member of the same minority, ethnic, cultural or linguistic group as the client;

(c) instances in which specialized skills or services are required and are not otherwise available;

(d) instances involving a crisis or emergency (p. 5).

The College of Alberta Psychologists *Code of Conduct* (2000) Section 11 Subsection 5 states:

Psychologists may continue to provide professional services in the circumstances described in subsection (4) if

(a) the client is informed of the possible or actual conflicting relationship and its possible consequences,
(b) a description of the relationship is included in the psychologist’s professional records along with a record of the discussion of the relationship with the client, and (c) consults with other psychologists are carried out, if useful or necessary, regarding the relationship and subsequent provision of professional services to the client (p. 5).

The College of Alberta Psychologists Guidelines for Child Custody Assessment (2002) states:

Psychologists clarify their roles in child custody situations and avoid multiple relationships that may impair their professional objectivity.

Psychologists in child custody situations must make clear role differentiations. They avoid mixing professional and personal relationships and they avoid multiple professional roles. Psychologists must clarify role expectations with parents and referring parties, as well as indicate their qualifications to conduct the assessment.

Dual relationships are occasionally unavoidable. Consequently, roles must be clarified and made known to all parties at the outset of an assessment to avoid both compromising the objectivity of the psychologist as well as the perception that objectivity has been compromised. Psychologists who accept more than one role must have carefully considered ethics and professional codes of conduct, engaged in a decision-making process to reach a sound rationale, and be able to defend their impartiality. (p. 3).

The Canadian Counselling Association Code of Ethics (1999) Section B, Counselling Relationships, Subsection B8, Dual Relationships states:

Counsellors make every effort to avoid dual relationships with clients that could impair professional judgment or increase the risk of harm to clients. Examples of dual relationships include, but are not limited to, familial, social, financial, business, or
close personal relationships. When a dual relationship can not be avoided, counsellors take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs (p. 6).

Feminist Therapy Institute *Feminist Therapy Code of Ethics* (1999), Section III, Overlapping Relationships, states:

(a) Feminist therapist recognizes the complexity and conflicting priorities inherent in multiple or overlapping relationships. The therapist accepts responsibility for monitoring such relationships to prevent potential abuse of or harm to the client. (b) A feminist therapist is actively involved in her community. As a result she is especially sensitive about confidentiality. Recognizing that her client’s concerns and general well-being are primary, she self-monitors both public and private statements and comments (p. 4).

As can be seen in reviewing the current codes of ethics, the governing bodies recognize that dual relationships are, in some cases, unavoidable and ethical. However, within the profession there remains the pervasive belief that dual relationships should be avoided. As such, it is possible that clients go without services as a result. The *Companion Manual to the Canadian Code of Ethics for Psychologists* (Sinclair & Pettifor, 2001) states:

Respect for the dignity of persons also includes the concept of distributive justice. With respect to psychologists, this concept implies that all persons are entitled to benefit equally from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists, regardless of the person’s characteristics, condition, or status (p. 14).
This ethical guideline and the tendency of mental health professionals to avoid dual role relationships contradict one another. The above ethical guideline can be interpreted such that to limit services due to the existence or potential development of dual role relationships is to deny individuals the mental health services to which they are entitled, based on their status as an individual with whom the mental health professional has a pre-existing nonsexual relationship. Current ethical guidelines are vague and overbroad, causing those who abide by them to avoid activities that are, in fact, ethical (Ebert, 1997).

Although dual relationships are not prohibited and are, in fact, recognized by governing bodies as being unavoidable in some situations, there continues to exist a conceptualization of dual relationships as hazardous forms of interaction between client and therapist. According to Lazarus and Zur (2002), this mindset is the result of past bans of dual relationships, a regulation that was embraced and continues to be adhered to by therapists who subscribe to traditional psychoanalytic methods and find the prohibition fits well with their desire to maintain a detached distance from clients. Additionally, these authors suggest that the litigious nature of society results in a sense of fear that inhibits the actions of psychologists, with the resultant risk management mindset leading to a more defensive form of interaction with clients. Risk management is defined as “the process whereby therapists avoid certain behaviors and interventions – not because they are clinically ill advised, harmful, or wrong, but because they may appear improper in front of judges, boards, or ethic committees” (Lazarus & Zur, 2002, p. xxxii). Finally, the authors theorize that, given the urban versus rural distribution of psychologists, most mental health professionals subscribe to a more urban-focused, psychotherapeutic framework, which is based on privacy,
anonymity, and strong boundaries, rather than the less traditional community-focused rural model.

*Ethical guidelines of provincial regulatory bodies.* While the CPA Code of Ethics makes it clear that dual relationships of a sexual nature should not be engaged in by psychologists, the ethical guidelines regarding nonsexual dual relationships are more ambiguous. The CPA acknowledges the fact that in some situations dual relationships are unavoidable, but gives little direction regarding the circumstances in which dual relationships are acceptable, and little assistance regarding methods of managing dual relationships. The majority of the provincial regulatory bodies provide a similar lack of support to psychologists who find dual relationships unavoidable. Examination of the websites of the regulatory bodies in Saskatchewan, Manitoba, New Brunswick, Nova Scotia, and Prince Edward Island yielded no information regarding nonsexual dual relationships. Due to the comparatively high percentage of rural dwellers in these provinces, it is a concern that no guidelines are easily accessible. Ironically, the provincial regulatory bodies that do have some information regarding dual relationships available on their websites are those with comparably low rural populations – British Columbia, Alberta, Ontario, and Quebec. The regulatory bodies for Yukon Territory, Northwest Territories and Nunavut did not have websites available. Based on the review of literature regarding ethics it appears that the rural psychologists of Canada are lacking clear leadership in regards to managing ethical dilemmas resulting from dual relationships.

*Professionals’ opinions of exiting ethical guidelines.* Little research exists on the topic of mental health professionals’ opinions of existing ethical guidelines and practices. Rossiter, Walsh-Bowers, and Prilleltensky (1996) conducted qualitative research in an effort
to develop a concise understanding of what psychologists think of current ethical practices as well as what they would like to see happen in the area of managing ethical dilemmas. The participants shared feelings of frustration resulting from a lack of supervision and impatience with existing rule-based guidelines. As stated earlier, codes of ethics are intended to encourage professionals to think and behave in a particular manner, not to set specific rules. The results of this study suggest that ethical guidelines are either too limiting or are not being perceived in the intended manner. Respondents expressed a desire to discuss ethically challenging situations in an open and honest manner, but believed that there was not a non-judgemental safe space in which to do so. A review of the responses revealed a number of reasons the participants were fearful of speaking in a manner that left them open to judgement: (a) a political and economic climate dominated by restructuring and downsizing, (b) the tendency to define professionals as individuals who know all the answers, (c) a perceived loss of power in discussing ethical dilemmas, (d) an atmosphere of distrust resulting from a decision-making process that failed to take into account the counsellors’ knowledge of clients, (e) the concept of accountability had therapists concerned that any ethical dilemmas discussed would be flagged as problems and could lead to future difficulties, and (f) funding cuts meant large caseloads and minimal supervision, leaving little time for discussion of ethical concerns. It is important to note that this research was conducted on a limited scale. The ten participants were employed by a family counselling agency in southern Ontario. Certainly, expanded research is required to explore the commonality of these experiences and feelings within the mental health profession. From these findings it can be seen that current ethical practices and guidelines, at least for those who participated in the research process, are ambiguous and unsupportive, leaving the
professionals to fashion individualistic action plans in an atmosphere of fear and secrecy.

This certainly is not healthy for the professional and most likely is not healthy for the clients.

More support is needed; the problem, particularly for rural psychologists who are often the only mental health professionals covering a large area, is figuring out how.

*Rural Areas and Small Communities*

Essential to developing an understanding of the practice of psychology in rural areas and small communities is having a clear understanding of how these geographical areas are defined. Unfortunately, there does not seem to be an agreed upon definition of these words. Often, “rural” and “small communities” are defined simply as everything that is not urban. Clarification of the meaning of these terms is necessary in the development of guidelines that are applicable to practice in these areas.

*Rural areas.* Generally speaking, areas are considered to be rural when there are a relatively small number of people living in the area and when access to large urban centres is restricted. While these definitions may be useful in some situations, it is rather ambiguous for the purpose of data collection or research. As is outlined by the Public Health Agency of Canada (PHAC) (2002), rural can be defined in a number of ways on a continuum from more rural to less rural. A Census rural area would encompass those who reside outside of towns with 1000 or more people, or those who live outside areas with 400 or more people per square kilometre. Regions designated as rural and small town would include those dwelling in towns or municipalities that are not within commuting distance of an urban centre with a population of 10,000 or more. Regions referred to as Organization of Economic Co-operation and Development (OECD) rural communities take account of individuals in communities with less than 150 persons per square kilometre. The OECDs include people living on farms,
in towns, and in small cities regardless of their proximity to larger urban centres. Localities known as Organization of Economic Co-operation and Development (OECD) predominantly rural regions contain persons inhabiting census divisions with more than 50 percent of the population living in OECD rural communities. Finally, non-metropolitan regions are composed of people living outside metropolitan areas with urban centres with populations of 50,000 or more. Statistics Canada simplifies these definitions somewhat, breaking urban locations into Census Metropolitan Areas (CMAs) and Census Agglomerations (CAs), and referring to any areas outside of CMAs and CAs as Rural and Small Town Areas (RSTs). CMAs are large urban centres and surrounding areas with a population of 100,000 or more. CAs are smaller urban centres with a population between 10,000 and 100,000. Both CMAs and CAs include neighbouring municipalities that have 50 percent or more of the workforce commuting to the urban centres. Clearly defining the meaning of rural is important as it can have a great deal of influence on research outcomes.

When considering the population of Canada in relation to the geographic size of the country, it is clear that there are many areas of the country that are sparsely populated. According to PHAC (2002), 9.5 million square kilometres, or around 95% of Canada's territory, is considered to be rural or remote. National statistics released by Statistics Canada in 2001 show that vast area to be occupied by approximately 6 million Canadians, about 20% of Canada's population. In looking at provincial population comparisons, rural population is highest in Nunavut at 67.5% and lowest in Ontario and British Columbia at 15.3%.

While there are a substantial number of Canadians living in rural areas, there are a comparatively low number of psychologists, making accessing mental health services a challenge for rural dwellers. Bazana (1999) compiled charts comparing the number of
registered psychologists in urban and rural areas. The statistics show that in urban areas there is 1 psychologist for every 2195 people, while in rural areas there is 1 psychologist for every 9619 people. The significantly smaller number of psychologists in rural areas is alarming when you consider that the psychological distress of rural dwellers is comparable to that of individuals living in urban areas, and at times can be higher. A quantitative study conducted by Hoyt, Conger, Valde and Weihs (1997) revealed that community size plays a role in psychological distress. The research showed that males living in villages with populations under 2,500 or in small towns with populations of 2,500 to 9,999 are more likely to experience intensification of depressive symptoms than men living on farms or in centres with populations of 10,000 or more. In a study that analysed the results of Statistics Canada’s 2000/01 Canadian Community Health Survey, Mitura and Bollman (2004) found a number of health-related differences between urban youth and rural and northern youth, ages 12 to 17. Thirteen percent of girls living in northern communities are predicted to experience major depressive episodes, a number which is noticeably higher than the national average of 9%. As well, both boys and girls living in northern areas rated their functioning health, which includes thoughts and affect, at 80% and 77%, respectively, 5% and 8% lower than the national average of 85%. It is obvious that there is a need for an increased number of psychologists in rural and remote areas of Canada. With improved clarity to guidelines regarding dual relationships, perhaps more professional would be willing to work in the areas where they are needed.

Small communities. Little attention has been given to the development of a clear definition for areas termed as small communities. When considering environments that contribute to the development of dual relationships it is important to bear in mind not only...
geographically small or isolated areas, but also close-knit micro-communities that may exist in urban areas. Such communities include those made up of individuals from specific cultures-of-origin, sexual orientation, disabilities, age groups, spiritual or religious orientation, or vocations (e.g., military). Just as with rural communities, it is not uncommon for these small communities to be served by a limited number of mental health professionals who specialize in working with individuals from these groups. Additionally, the individuals serving these communities may fill multiple professional roles and/or have a common history with clients (Guthmann & Sandberg, 2002). As such, even when the micro-communities may be located in large centres, nonsexual dual role relationships develop and mental health professionals serving these population-specific small groups would benefit from clear and consistent ethical guidelines regarding the management of dual role relationships.

Counselling does not take place in a void – the context in which it occurs can significantly impact the therapeutic process. In urban areas it is possible to maintain relative anonymity, making the maintenance of strong boundaries expected, if not desired, in interpersonal relations. However, in the context of rural areas and small communities there is much overlap in relationships. Family-owned businesses remain common and, more generally speaking, there is a prevailing sense of shared responsibility for the wellness of all community members. Due to the values and morals subscribed to by the community members, the blurring of personal and professional boundaries are an everyday occurrence. In order to provide effective counselling services it is vital that mental health professionals be cognizant of and responsive to the customs and expectations specific to the context in which they work. Having clear and consistent guidelines regarding the management of boundary
crossings and dual relationships would enable psychologists practicing in rural areas and small communities to function more effectively both professionally and personally.

**Boundaries**

It is important to understand the nature of professional boundaries and nonsexual dual relationships, particularly in the context of a rural location. Boundaries play a vital role in healthy functioning and safety (Gampel, 1998). Professional boundaries can be defined as “a psychological space or distance between individuals, one that is used to emphasize the clinician’s stance of anonymity, neutrality and objectivity” (Scopelliti et al., 2004, p. 955). According to Smith and Fitzpatrick (1995), professionals who maintain boundaries give clients a sense of safety. This sense of safety contributes to the development of trust, a key element in the creation of a strong working alliance. While responsibility for the maintenance of professional boundaries lies primarily with the professional, either the clients or service providers can act in a manner that crosses those limits.

**Boundary crossings and boundary violations.** In developing an understanding of professional boundaries it is important to differentiate between boundary violations and boundary crossings. According to the literature review conducted by Scopelliti et al. (2004), boundary violations occur when the professional acts in a manner that is manipulative, destructive, or disrespectful. Included in boundary violations are financial or sexual exploitation of the client. Boundary crossings, while not in keeping with traditional counselling practices, are seen to be well-meaning, harmless, and possibly of benefit to the client. An example of a boundary crossing would be conversing with a client at a social event. In an effort to better understand how therapist and client characteristics such as therapist’s sex, client’s sex, stress levels, therapist’s theoretical orientation and interpersonal
boundaries influence the therapist’s evaluation of boundary-related ethical dilemmas, Baer and Murdock (1995) surveyed 223 randomly selected APA members. It is important to note that the interpersonal aspects of this survey were based on the theory that individuals who successfully differentiate from their families are better able to maintain interpersonal boundaries, particularly during times of stress. Results of the quantitative research showed that participants who were deemed to be low-differentiated were more open to boundary crossings and dual role relationships when under high levels of stress than when under low levels of stress. Clearly it is important for mental health professionals to manage and reduce stress not only for their own health, but also to protect their therapeutic relationships with their clients. Further results from the Baer and Murdock study show that, in contrast to previous research by Pope and Vetter (1989), the sex of client and therapist did not have an impact on the participants’ evaluations. Baer and Murdock speculate that this change may be the result of psychologists becoming non-sexist in their work.

*Maintaining healthy boundaries.* For all health professionals, including those who provide mental health services, working in a rural area presents some unique challenges regarding maintaining healthy boundaries with clients. Rural psychologists participating in a qualitative study conducted by Schank and Skovholt (1997) shared that they frequently face complex dilemmas regarding professional boundaries. In the interview process, four main themes emerged regarding boundaries:

(a) the reality of overlapping social relationships, (b) the reality of overlapping business or professional relationships, (c) the effects of overlapping relationships on member’s of the psychologists own family, and (d) working with more than one
family member as clients, or with others who have friendships with individual clients.

(p.46)

Research conducted by Perkins, Hudson, Gray, and Stewart (1998) confirms Shank and Skovholt’s findings that rural mental health professionals frequently experience ethical dilemmas related to boundary issues. Perkins et al. surveyed 95 mental health centre staff members (27 were from rural areas and 68 were from urban areas), asking respondents to make and justify ethical decisions based on vignettes describing boundary related situations. In addition, participants were asked to share the number of boundary violations similar to those in the vignettes they had experienced. Analysis of the results showed that not only did rural mental health practitioners have more encounters with boundary related ethical dilemmas, but they respond to them in a less conservative manner than their urban counterparts. It would be useful to replicate this study with psychologists across Canada in order to develop ethical guidelines relative to the experience of rural psychologists and those working with population-specific small communities.

Maintaining clear and professional boundaries within dual role relationships is vital for the therapeutic relationship to function in a healthy manner. Resultant of a review of existing literature, Simon and Williams (1999) offer the following guidelines for maintaining boundaries: (a) maintain a neutral perspective with clients, (b) encourage and empower the client to develop a separate identity in the counselling process, (c) ensure information remains confidential, (d) receive informed consent from the client for all aspects of the treatment process, (e) verbally connect with the client, (f) limit physical contact, (g) do not engage in personal relationships with the client before, during or after treatment, (h) limit self-disclosure in an effort to maintain anonymity, (i) accept only money for services, do not
barter or exchange services for goods or other services, and (j) meet with clients in a venue that is private, professional and consistent. While the majority of these guidelines can be utilized in rural practice, it can be challenging for rural practitioners to avoid treating clients with whom they have had a personal relationship, either as a friend or relative. It can also be difficult to avoid having a personal relationship with clients after the treatment process has ended.

Undoubtedly, the majority of mental health professionals strive to maintain healthy boundaries in their relationships with clients. In the event that a therapist is unsure, Haas and Malouf (1989, as cited in Campbell & Gordon, 2003) identified a number of signs that warn of the existence of boundary conflicts in dual relationships: (a) increased self-disclosure to a client, (b) increased anticipation of meeting with a client, (c) a desire to prolong a session with a client, (d) failure to terminate or refer a client, and (e) a desire to please, impress or punish a client. When it is necessary to maintain dual relationships with clients, it is essential to be aware of the indicators that signal a problem with the relationship, and to act to rectify the situation.

Boundaries ensure the healthy functioning of systems and relationships, but this does not mean there is a need for inflexibility. In fact, the opposite can be said to be true. Boundaries that are fluid and based on the current needs of each client can be said to promote a more healthy therapeutic relationship, particularly during stressful periods. As an example, think of the fragility of a china teacup versus that of a rubber ball. Because the boundaries of the ball are soft and fluid, when the ball is dropped there is not a detrimental effect, whereas if you drop the teacup, which has very little fluidity or flexibility to its boundaries, the cup will likely shatter. In applying this metaphor to the therapeutic relationship, flexibility
regarding boundaries, and being willing to engage in boundary crossings that are an intentional aspect of the therapeutic intervention and, hence, are beneficial to the client, can result in increased efficacy in the counselling process.

**Dual Relationships**

When there is a blurring of personal and professional boundaries, dual relationships develop. Common to most rural communities is a significant geographic distance between people and communities, and limited services and resources within the communities. This contributes significantly to the existence of dual relationships. Another contributing factor is the length of time a professional has been in a community. The longer the individual provides mental health services in a community, the greater the chance for dual relationships to form. In small communities, the clients seen professionally by the psychologist may be the lawyer, the clerk at the grocery store, the hairdresser, the mother of their child’s friend, a member of their ball team, or their next-door neighbour. According to Pope (1991), a dual relationship exists when the professional has a therapeutic relationship with a client as well as a significantly different relationship, such as social, financial, or professional role with that client. In a survey of randomly selected members of the APA, Pope and Vetter (1992) found that the dilemma of dual role relationships was the second most distressing problem encountered by the respondents. In order to improve the response rate of the survey, Pope and Vetter eliminated questions regarding gender, age, and location of practice. While this did increase the response rate to 51% from a previous average of 15%, there is no possibility of comparing and contrasting responses from psychologists practicing in urban versus rural areas. This comparison would certainly be valuable information in the development of ethics relevant to rural practice and is a direction for future research in this area.
Arguments regarding dual role relationships. Two opposing schools of thought exist regarding the appropriateness of nonsexual dual relationships between mental health care providers and clients. Those opposed to dual relationships believe they are harmful to the client and should be avoided completely (Moleski & Kiselica, 2005; Nigro, 2004; Pope, 1991; Reilly, 2003; Scopelliti et al., 2004). Professionals who support this position believe in maintaining rigid limits between client and professional by not seeing the client outside of office time, and by not sharing personal information or experiences with the client. Dangers that may result from participating in dual relationships include resentments, dependencies, and emotional or financial bonds (Reilly, 2003). In addition, the existence of a dual relationship may result in either client or professional expecting to receive special treatment such as lower rates for services, invitations to social events, or other favours.

In contrast to those who believe dual role relationships are harmful and must be avoided, there are professionals who believe that dual relationships are unavoidable in some situations and can, in fact, have a positive impact on the working alliance, with the potential to benefit the client (Barnett & Yutrzenka, 1994; Dineen, 2002; Ebert, 1997; Fay, 2002; Guthmann & Sandberg, 2002; Reamer, 2003; Scheflin, 2002; Williams, 2002; Younggren, 2002; Zur, 2001). Supporters of dual relationships believe that there are increased levels of familiarity, understanding and connection, all of which contribute to the successfulness of the therapeutic process. Mental health practitioners who live and practice in small communities are familiar to residents, making them more approachable. In addition, dual relationships reduce the likelihood of exploitation by the professional because the power differential is reduced, resulting in a more egalitarian relationship.
Zur and Lazarus (2002) identify six arguments against dual relationships and refute each of these arguments. As described by these authors, the arguments against dual relationships include the importance of maintaining clear boundaries, the “slippery slope” argument, power differential and resultant exploitation, excessive levels of familiarity and transference issues, risk management, and incidental out-of-office encounters. With regards to the claim that failure to maintain clear boundaries reduces one’s ability to remain objective in the counselling process Lazarus and Zur argue rigidness and inflexibility can impede a therapist’s ability to best meet the needs of the individual client. Those who subscribe to the “slippery slope” argument believe that any boundary crossings will undoubtedly lead to exploitative and damaging actions on the part of the therapist. In response, the authors argue that this sexualization of boundaries results in a compartmentalization of clients that is isolating in nature. Further, the isolation created by the maintenance of inflexible boundaries increases the occurrence of exploitation (Singer & Lalich, 1995; Walker, 1994). Those who believe dual relationships should be avoided base their argument on the assumption that therapists will utilize the power differential within the working alliance to exploit their clients. Zur and Lazarus refute this belief with the argument that while power differentials exist in many types of relationships, and boundary crossings occur in those relationships, exploitation is not an inherent factor. Exploitation is associated with the individual therapist’s lack of responsibility more so than to the existence of power differentials or boundary crossings. Proponents of avoiding dual relationships believe that excessive levels of familiarity that result from boundary crossings sully the therapeutic process and dull the therapist’s ability to detect transference. Zur and Lazarus counter this line of thinking with the argument that the social expectations of rural and small communities are such that
boundary crossings are inherent to all relationships. Further, professionals who engage in boundary crossings and dual relationships are perceived to be warm, caring, and genuine, thereby increasing their approachability and effectiveness as a therapist. Risk management is seen by some to be an important aspect of the practice of psychology and, as such, avoid engaging in dual relationships. Zur and Lazarus argue that this fear-based ideology can be harmful to clients because they are denied counselling services or therapeutic interventions best suited to their needs. Finally, incidental out-of-office encounters are viewed negatively by some because it disrupts the therapeutic process and leaves both client and therapist feeling anxious and uncomfortable, particularly with regards to privacy and confidentiality. In response, Zur and Lazarus suggest that such encounters give clients an opportunity to view therapists in a more human light and give therapists the opportunity to view clients in an informal environment and potentially reduce any pathologization that may have occurred. As such these out-of-office encounters can strengthen the working alliance and benefit the counselling process. As Zur and Lazarus point out, in order to maximize the potential benefits of these encounters it is important to discuss their potential occurrence and impact with clients in initial sessions.

Counselling framework and dual role relationships. The operational framework utilized by mental health professionals can impact the level of risk attached to engaging in dual relationships with clients. Therapists who subscribe to psychodynamic and/or analytic modalities of therapy are more likely to view nonsexual dual relationships as being more risky than are therapists who utilize behavioral, feminist, humanistic, and/or eclectic methodologies (Boland-Prom & Anderson, 2005; Williams, 1997). A common thread in these therapeutic modalities is the emphasis on empowering clients by reducing the power
differential between client and professional. Further, interventions collaboratively agreed upon by client and professional, specific to achieving the client’s goals in counselling, may include activities that necessitate boundary crossings. In the name of client empowerment and growth, common boundary crossings include self-disclosure, modeling, accepting gifts, socializing, and non-sexual physical contact such as hugging (Williams). Clearly, therapists who operate wholly or in part from these perspectives purposely utilize interventions that would be categorized as severe boundary violations by some. While traditional and eclectic counselling perspectives differ on many points regarding entering into dual role relationships, there are some commonalities. These include the therapist being responsible for setting and preserving healthy boundaries, determining the susceptibility of clients to any possible harm resultant of dual role relationships, ensuring clients have the to understand and give fully informed consent regarding the risks and benefits of dual role relationships, and accurately documenting the dual role relationship (Boland-Prom & Anderson).

_Dual role relationships and the working alliance._ Counselling is a collaborative process that requires both counsellor and client to play active roles. Often, the client-counsellor relationship is therapeutic in and of itself (Catty, 2004; Horvath & Symonds, 1991; Sauvayre, 2002; Werner-Wilson, Michaels, Gellhaus Thomas, & Thiesen, 2003). In addition, the strength of the working alliance is of fundamental importance regarding the successful outcome of counselling (Gelso & Carter, 1994; Horvath & Symonds, 1991). In a review of 24 studies evaluating the relationship between working alliance and treatment outcome, Horvath and Symonds found that not only is the quality of the working alliance a predictor of positive counselling outcome, but that the quality of the working alliance does not seem to be affected by the type or length of treatment. These studies provide evidence for
the importance of creating a positive client-counsellor bond in order to facilitate a successful
counselling experience. In order for the client to maximize opportunities for progress it is
necessary for the client to feel safe, supported, and free to express all thoughts, feelings,
beliefs and perceptions. How clients respond to therapists and how therapists respond to
clients seems to be an important piece of the client-counsellor relationship. Therapists who
are empathic, genuine, sincere, self-assured, caring, comfortable with ambiguity, aware of
personal strengths and limitations, and able to convey a strong sense of positive presence are
best able to engage their clients, build a trusting relationship, and increase the client’s belief
in the therapist’s ability and in their ability to change (Kottler, 1991; Pipher, 2003).

In looking at the connection between boundary crossings, dual relationships, and the
working alliance it can be seen that boundary crossings and dual relationships increase the
potential for positive impact (Tomm, 1993; Zur, 2000). Therapists who strive to remain
distant and detached in order to avoid boundary crossings and dual relationships are more
likely to be perceived by clients as cold and aloof. As stated by Tomm, to remain detached in
order to avoid dual relationships creates “artificial professional cleavage in the natural
patterns that connect us as human beings” (p. 8). Further, the proclivity to remain distant and
detached fosters isolation and disaffection and encourages an increase in the power
differential between client and therapist. The additional human connectedness that results
from boundary crossings and dual relationships can be said to be affirming and reassuring,
creating working alliances that are more honest, authentic, and mindful. Within such working
alliances there is a greater level of connectedness, an increased sense of safety, more honesty,
and decreased power differential. In many situations boundary crossings and dual
relationships allow for greater opportunities for developing trusting and meaningful
therapeutic alliances. This, in turn, increases the efficacy of the counselling process, ultimately benefiting the client.

*Categorization of dual role relationships.* In order to better understand the impact of dual relationships Anderson and Kitchener (1996) conducted a qualitative exploratory study regarding nonsexual relationships between psychologists and former clients. Participants were asked to describe up to three examples of nonsexual relationships that had occurred or were occurring between themselves and individuals who had previously been clients. Anderson and Kitchener then divided the responses into eight categories: “(a) personal or friendship relationships, (b) social interactions or events, (c) business or financial relationships, (d) collegial or professional relationships, (e) supervisory or evaluative relationships, (f) religious affiliation relationships, and (g) workplace relationships” (pp. 61-64). From this study Anderson and Kitchener concluded that while there is a lack of consensus on the ethics of nonsexual dual relationships, psychologists are engaging in said relationships with former clients, and as a result are manoeuvring through complex issues with little guidance from the professional governing bodies.

While Anderson and Kitchener’s system of categorization can be useful in exploring and understanding dual relationships, Pearson and Piazza (1997) argued that the Anderson and Kitchener system of categorization is too restrictive to be useful in many situations. Instead, Pearson and Piazza offered a system of classification based on the manner in which the relationships developed, with the categories labelled as: “(a) circumstantial multiple roles, (b) structured multiple professional roles, (c), shifts in professional roles, (d) personal and professional role conflicts, and (e) the predatory professional” (p. 89-93). Pearson and Piazza theorized that because dual relationships develop gradually over time, as a result of a
breakdown of boundaries between counsellor and client, the categorization of those relationships should reflect the circumstances in which they develop.

In order to better understand the impact and management of dual relationships in urban and rural settings in Australia, Endacott et al. (2006) conducted focus groups with mental health clinicians; 24 participants worked in rural areas, while 14 participants practiced in urban areas. The results showed that incidental encounters with clients were the main venue in which dual relationships occurred. Responses from the rural practitioners revealed that such encounters occurred in all locals; simply living and practicing in a rural community was seen as a dual relationship. Conversely, urban practitioners shared that they rarely encountered clients out of the office and, hence, dual relationships were rare. Primarily based on the responses from rural practitioners the researchers found that the dual relationships had both positive and negative impacts, with much of the negative impact being on the therapists’ personal lives and on the lives of their family members. The positive impact was related to professional practice, specifically by offering greater opportunity for understanding clients at a deeper level.

Psychologists’ opinions of nonsexual dual relationships were explored further when Nigro (2003) analysed the results of a portion of a survey of British Columbian members of the Canadian Guidance and Counselling Association. In the survey, participants were asked to rate dual relationship situations between psychologists and current clients on a five-point scale ranging from “never ethical” (1) to “always ethical” (5). The nonsexual dual relationship examples were representative of Anderson and Kitchener’s eight categories. Of the dual relationship examples that were nonsexual in nature, respondents rated those that were financial, social, or professional in nature as the least ethical, while the examples that
were circumstantial encounters or incidental boundary crossings were considered to be the most ethical.

In order to better understand the problems resulting from dual relationships, Nigro (2004) analysed the results of the same survey of British Columbian members of the Canadian Guidance and Counselling Association, which included both quantitative and qualitative style questions. In examining the responses to the open-ended questions it was found that the types of dual relationships experienced by the participants in order from most to least were circumstantial, professional, workplace related, business or financial, client overlaps, social, familial, and incidental boundary crossings. From the 165 problematic aspects of dual relationships that were identified by the counsellors, eleven themes emerged: (a) the counsellors felt uncomfortable, (b) the counsellors felt role conflict, (c) the counsellors experienced an impact on personal life, (d) the counsellors experienced real or potential confidentiality/anonymity concerns, (e) the counselling relationship was impacted in a negative manner, (f) the counsellors had little alternative to avoid the dual relationship, (g) the dual relationship had a negative impact on non-therapeutic relationships, (h) the counsellors perceived discomfort on the part of their clients, (i) the counsellors believed they were less able to remain objective, (j) the counsellors feared being negatively judged by colleagues, (k) the counsellors saw a power imbalance as a result of the dual relationship. The responses of the participants in this study suggest that dual relationships have a negative impact on the counselling relationship and should therefore be avoided.

Nigro’s (2004) findings that psychologists feel uncomfortable as a result of dual role relationships were reflective of earlier research conducted by Sharkin and Birky (1992). Their study used open-ended questions, checklists and a rating scale to determine therapists’
emotional reactions and concerns regarding confidentiality and boundary violations as a result of incidental encounters with clients. Results of the study show that therapists’ most common emotional responses were surprise, uncertainty, and discomfort. Additionally, 60% of the respondents were anxious about confidentiality violations, while 73% were concerned about boundary violations. In a comparative study conducted by Palukos (1994), clients of a counselling centre were asked to complete a questionnaire regarding incidental encounters with their therapist. The intent of the study was to explore clients’ feelings about incidental encounters. Results showed that while only 59% of the respondents had had incidental encounters with their therapists, their emotional responses to the encounters were positive and included feelings of confidence, surprise, enjoyment and curiosity. In comparing the emotional reactions of counsellors and clients to incidental encounters it would appear that clients are more comfortable than counsellors when chance meetings occur. While the studies that reflect this are limited by in the degree to which they can be generalized to large populations, the finding is worth further investigation in order to develop guidelines that accurately reflect the values and practices of society.

While Nigros’ (2004) research may suggest that dual relationships should be avoided, it is interesting to note that 80% of the respondents work in urban settings, 19% work in rural areas, and 1% did not state their locale. As stated earlier, results from the research conducted by Perkins et al. (1998) suggests that rural practitioners have more experience dealing with dual relationships and therefore may feel more comfortable with and confident in their ability to manage them. In Nigro’s research, the bias against dual relationships that emerges in the participants’ responses may be reflective of the locales in which they worked.
While dual relationships may have the potential to be harmful to clients, in rural practice they are often unavoidable. Resultant of the literature review regarding dual relationships and mental health practice, Scopelliti et al. (2004) determined that there are three main factors that influence the ability of a professional to preserve role boundaries and limit the existence of dual relationships: “(a) the size of the community, (b) the isolation of a community, and (c) the expectations of the community” (p.954). As was already stated, the smaller the community, the less able the professional is to limit social contact with residents, and the fewer the services are available to the residents. While the professional may feel uncomfortable in providing services to a client with whom he has a social relationship, there may be no one else available to provide that service.

The reality in rural areas and small communities. Clearly, in some cases it is not a matter of deciding whether to be involved in dual relationships, but how to manage them. In smaller and more isolated communities the professional has fewer options for social and commercial interactions outside the community, and residents have limited access to outside services. Professionals who attempt to avoid dual relationships by accessing services (e.g. grocery shopping) outside of the area in which they practice face an additional problem. Businesses in rural communities are struggling to survive in this age of big box discount stores and those who access services outside of the community run the risk of being viewed negatively by community members. This can be detrimental to developing and maintaining positive working alliances within the community.

While boundary crossings and dual relationships are unavoidable in rural practice, this is not clearly acknowledged and addressed in literature, textbooks, and ethics codes. In reviewing existing literature regarding the practice of psychology in rural areas, the existence
of an urban bias was identified by numerous authors (Barbopoulos & Clark, 2003; Ebert, 1997; Helbok, 2003; Prilleltensky, Rossiter & Walsh-Bowers, 1996; Roberts, Battaglia & Epstein, 1999; Rossiter, Walsh-Bowers & Prilleltensky, 1996; Schank & Skovholt, 1997). That bias was exemplified in the Exploitation Index developed by Epstein and Simon (1990). Epstein and Simon reviewed the literature regarding boundary violations and created a resultant index regarding the degree of exploitation psychologists were engaging in when boundary crossings and boundary violations occur. Examples of activities considered to be exploitative are the use of the client's first name, treating individuals who are referred by clients, treating clients who are within your social or family circle, having a personal relationship (friendship) with a client following the termination of treatment, and engaging in business relationships with patients. For a psychologist who encounters a client often in the community and is familiar with that client, to revert to the use of a more formal title than the first name would create an atmosphere of discomfort and falsity. In rural and remote areas where there is a lack of mental health professionals, there is often no other therapist to treat potential clients the professional associates with socially, is related to, or are referred by a current or former client. In regards to the question of business relationships, there are examples in the literature of psychologists having little choice but to treat the individuals from whom they rent office space. Boundary crossings and dual relationships that are considered exploitative by urban practitioners are often a necessary aspect of practice in rural areas. Rural psychologists who are frustrated by the urban bias can take heart in the possibility that there may be a perceptible shift taking place. Nine years following the publication of the Exploitation Index, Epstein, who co-authored the Index, was a co-author of a paper that stated “sources of information about ethical dilemmas…are so urban biased or
culturally incongruent that they are unhelpful in remote communities” (Roberts, Battaglia, & Epstein, 1999, p. 501).

In rural areas and small or micro communities it is difficult if not impossible to refrain from entering into dual role relationships. Additionally, to maintain the level of distance necessary to avoid such relationships may put individuals in need of mental health services at risk and negatively affect the professional’s ability to function at professional and personal levels within the community. Mental health professionals working in rural areas and small communities regularly face the question of how to successfully manage the challenges inherent to entering into and maintaining dual role relationships with clients. According to the CPA Code of Ethics (2000), four principles – respect for the dignity of persons, responsible caring, integrity in relationships, and responsibility to society – should form the basis of ethical decision-making. However, these principles are intended as guidelines and do not foresee or speak specifically to all possible ethically challenging situations. As such, it is up to each individual psychologist to employ an ethically sound decision-making process that will stand up to the scrutiny of peers and governing bodies (Sinclair & Pettifor, 2001). As stated by Pope and Vasquez (1991), while ethics codes are useful in directing actions in a non-harmful manner, creative and conscientious thought also plays an important role in making ethically sound decisions regarding client care. It is important that when making such decisions mental health professionals also take into account the context in which they are working, the experiences of their clients and themselves, and professional training they have received (Barnett & Yutrzenka, 1994). Standards of practice specific to managing personal-professional boundaries in rural and small communities are needed.
There seems to be a general consensus regarding situations where dual role relationships are not advisable – when therapy is intensive or long term, or when the client suffers from specific personality or psychotic disorders (Schefflin, 2002; Zur & Lazurus, 2002). Researchers suggest that informal assessments can be utilized to rule out Axis II diagnoses (as set forth in the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders, 5th ed.*, 2002) that can make it difficult for clients to manage the increased complexity of boundaries within dual role relationships. The personality traits inherent to individuals with Axis II diagnosis increase their susceptibility to misconception and transference in their relationships with others. As such, these vulnerable clients benefit from clear, predictable boundaries that may be difficult to provide within multiple relationships.

**Decision-Making Models**

*Schank and Skovholt.* Clearly, it is important for mental health professionals working in rural communities to develop strategies for managing dual relationships. In the course of their research regarding rural psychologists’ experiences with dual relationships, Schank and Skovholt (1997) identified three different methods utilized by mental health practitioners when contemplating entering into dual relationships: (a) the practitioners assess their own comfort level in managing the intersecting relationships successfully, (b) the practitioners involve the clients in the decision-making process, or (c), the practitioners make the decision based on the type and severity of the clients’ problems. Dual relationships present risks for both the client and the professional.

*Younggren.* When making choices regarding entering dual relationships, Younggren (2002) suggested psychologists ask themselves the following questions: (a) is the dual
relationship necessary, (b) is the dual relationship exploitative, (c) who does the dual relationship benefit, (d) is there a risk that the dual relationship could damage the patient, (e) is there a risk that the dual relationship could disrupt the therapeutic relationship, (f) is the matter being evaluated objectively, (g) has the decision-making process been adequately documented in the treatment records, and (h) did the client give informed consent regarding the risks to engaging in the dual relationship? Prior to entering into a dual relationship with a client it important to openly discuss roles and expectations in order avoid future conflicts.

*Campbell and Gordon.* As an outcome of a review of existing literature on rural practice and dual relationships, Campbell and Gordon (2003) offered the following guidelines for managing dual relationships: (a) at all times, and regarding all decisions, imagine the worst case scenario, (b) consult with colleagues and document the consultation in the client’s file, (c) uphold clear boundaries in as many areas as possible, (d) preserve confidentiality, and (e) end the dual counselling, social, or business relationship as soon as possible. When entering into a dual relationship with a client it is important for the professional to speak with the client about the possibility of contact outside of the therapeutic context, and how this contact will be dealt with. Doing so shares the decision-making process with the client, thereby empowering the client and reducing the power imbalance that exists between therapist and client. When social contact does occur, it is suggested that the professional to wait for the client to initiate interaction.

*Ebert.* Based on a review of the literature regarding dual relationships Ebert (1997) suggests that mental health professionals review a detailed list of factors when considering entering into dual relationships. It is important to note that Ebert refers to the therapeutic relationship as the primary relationship and any other relationship as the secondary
relationship. Ebert provides an extensive list of variables to consider: the nature of the therapeutic relationship (length, counselling framework utilized), the nature of secondary relationship, the closeness of secondary relationship, the potential risks of harm to client, the alternatives available, the length of time the secondary relationship is expected to last, the intensity of the secondary relationship, the potential that the therapist’s judgement will be impaired by the secondary relationship, the potential for the psychologist to benefit personally as a result of their influence over the client, the likelihood that the therapist will be restricted in choosing/implementing techniques or interventions, the potential for the client’s discussion to be inhibited in counselling, the possibility that the client will feel less inclined to return to counselling in the future, the potential challenges of maintaining a professional relationship outside of counselling, the potential existence of conflicts of interest currently or in the future, the possible impact the secondary relationship will have on the public’s perception of the profession, the particular interest pursued by the therapist, the possibility for that interest to be harmful to the client, the likelihood that geographic and cultural contexts will permit for the secondary relationship to exist, and the ability of the psychologist to maintain the psychological stability necessary to interact with the client in a healthy manner outside of the office.

Endacott. In the previously mentioned research conducted by Endacott et al. (2006) regarding the impact and management of dual relationships, the participants employed a number of professional and personal strategies in managing dual relationships resultant of living and working in rural areas and small communities. Professional strategies included the utilization of criteria by which to establish whether the maintenance of two distinct relationships with the client was advisable, and the determination and accessing of
organizational support. Criteria used to determine the continuation of dual relationships included the acuity of diagnosis, severity of illness, poor outcomes of a previous personal or professional relationship with the individual, level of closeness in pre-existing relationship, and expected duration of counselling services. Practitioners indicated that if these conditions were absent or minimal they were more likely to enter into and maintain dual relationships with clients. All participants who engaged in such relationships indicated they accessed professional supervision for the duration of the dual relationships and obtained informed consent from the clients. Organizational strategies employed by the participants included clarification of policy regarding dual relationships and relying on organizational members for support, supervision, and debriefing.

In the focus groups conducted by Endacott et al. the participants shared that their personal lives, particularly social relationships, were noticeably impacted by the dual relationships that arose resultant of living and practicing in rural and small communities. In order to minimize this impact the participants utilized a number of strategies: living outside the area they serve, accessing services outside of service area, and avoiding social activities. The group members also mentioned the impact on family members and suggested the importance of educating families on understanding and managing professional boundaries. With respect to social dual relationships Scheflin (2002) agrees that while sound professional judgement should not be over-ridden by fear at times it is important for therapists to utilize caution when considering entering into dual relationships. He suggests that some psychologists, particularly those who are new to the profession or new to working in a rural area or small communities, may initially feel most comfortable operating within the strict boundaries that exclude dual relationships.
Sharkin and Birkey and Palukos. In response to incidental encounters with clients, it is suggested that psychologists address the clients’ reactions and feelings in response to the encounters at the next meeting. However, research indicates that mental health professionals may not be consistently following this procedure. Sharkin & Birky, (1992) reported that of the therapists they surveyed regarding incidental encounters with clients, only 32 % initiate discussion of the encounter in the following session, while 20% let clients initiate discussion of the encounter, and 43 % do not address the encounter at all. The previously mentioned study by Palukos (1994) that examined client reactions to incidental encounters found that 72% of the clients surveyed reported that the encounter was not addressed by the therapist in the subsequent meeting. In recent years researchers have developed strategies intended to assist mental health professionals in managing unavoidable dual relationships and in recognizing when those relationships become toxic. Yet psychologists appear to be inconsistent in utilizing these and other strategies. While psychologists practicing in urban areas may have the luxury of choosing whether or not to enter into dual relationships with clients, it would appear that those practicing in rural areas and small communities do not have that option. By choosing to live and practice in such areas these professionals have implicitly entered into innumerable potential dual relationships with their clients. In order for any of these decision-making models to be adopted in a meaningful manner by psychologists practicing in rural areas, leadership from the provincial regulatory bodies and the CPA is critical. Setting forth clear and consistent guidelines for managing the dual relationships inherent to practice in rural area and small communities would offer support and protection for psychologists and consumers.

Conclusion
In reviewing the literature regarding ethics, boundaries, dual relationships, and decision-making models as they relate to practice in rural areas and small communities, it can be seen that while the ethical guidelines of the main governing bodies of psychological practice recognize that, at times, dual relationships are unavoidable, there remains the pervasive belief that such relationships are inherently harmful to clients and are therefore avoided. The propensity to avoid dual relationships is the result of messages from four sources: provincial and national regulatory bodies, therapists who work from a traditional framework, the litigious nature of society, and the bias towards the urban versus rural community paradigm. Due to the prevailing belief that all dual relationships are harmful and encourage exploitation, psychologists act out of fear and engage in risk management practices that may, in fact, prevent clients from benefiting from interventions that best suit their needs.

For psychologists working in rural areas and small communities, the avoidance of dual relationships is often not an option. Currently these mental health professionals are left to design their own strategies for entering into and managing dual relationships. Undeniably there is a need for unambiguous guidelines regarding dual relationships that are relevant to the practice of psychology in rural areas. Boundary crossings and dual relationships that are considered to be exploitative by urban practitioners are often a necessary aspect of practice in rural areas. The current lack of direction from the CPA and provincial regulatory bodies leaves rural practitioners with little choice but to analyse their own personal experiences with dual relationships and develop their own set of standards based on those experiences. Having ethical guidelines that clearly reflect the experiences of rural practitioners would benefit both psychologists and their clients.
CHAPTER IV

Recommendations

The ethical guidelines suggested in this section are founded on general principles derived from the *Canadian Code of Ethics for Psychologists* (CPA, 2000). The recommendations are organized around the four principles that form the structure of the *Code*, namely Principle I: Respect for the Dignity of Persons, Principle II: Responsible Caring, Principle III: Integrity in Relationships, and Principle IV: Responsibility to Society. This application of the ethical principles set forth by the *Code* is specific to entering into and managing dual relationships in rural areas and small communities.

The guidelines incorporate suggestions made by authors from the United States, Canada, and Australia for addressing ethical dilemmas encountered by mental health professionals practising in rural areas and small communities (Barnett & Yutrzenka, 1994; Boland-Prom & Anderson, 2005; Campbell and Gordon, 2003; Ebert, 1997; Endacott et al., 2006; Palukos, 1994; Schank & Skovholt, 1997; Schefflin, 2002; Sharkin & Birky, 1992; Younggren, 2002; Zur & Lazurus, 2002). Appendix A quotes in full the relevant standards from the *Canadian Code of Ethics for Psychologists* (CPA, 2000). Appendix B provides the *Ethical Guidelines Regarding Nonsexual Dual Role Relationships* in stand-alone format.

**Principle I: Respect for the Dignity of Persons**

This principle requires mental health professionals value the moral rights of the individual, appreciate each person’s innate worth, and take great care in ensuring the well-being of those in vulnerable positions, thus respecting the dignity of each person. When working in rural areas and small communities there can be a blurring of boundaries that can reduce objectivity and make this process more difficult. As such, mental health professionals
must strive to act in a manner that demonstrates their ability to maintain healthy boundaries with clients while functioning in an environment that makes it difficult if not impossible to avoid dual relationships in some form. When dual relationships are present psychologists need to acknowledge their existence and avoid exploitation based on knowledge gained of the client resultant of either relationship. In working collaboratively with the client and through the process of informed consent mental health professionals will explain the concept of dual relationships and discuss potential positive and negative impact on privacy and confidentiality, working alliance, and counselling outcomes.

When entering into dual relationships mental health professionals should make every effort to:

1. Involve the client in the decision-making process regarding entering into a dual relationship, giving consideration to the client’s reasoning for/against a dual relationship, while maintaining ultimate responsibility for the client’s well-being (CPA, 2000, I.1, I.12, I.13, I.36).

2. Utilize an informed consent document that clearly delineates the benefits and risks inherent to dual role relationships, including potential limitations to confidentiality and privacy (CPA, 2000, I.1, I.12, I.16, I.17, I.21, I.23, I.24, I.27).

3. When working with children and clients of diminished capacity, ensure that the concept and potential impact of dual relationships inherent to practice in rural areas and small communities is discussed with the client as well as with parents/guardians to ensure informed consent is obtained (CPA, 2000, I.12, I.16, I.17, I.19, I.21, I.23, I.24, I.33, I34).

_Prinicple II: Responsible Caring_
The Principle of Responsible Caring requires that, in the very least, the actions of mental health professionals will lead to no harm and, rather, be of benefit to others. It is the responsibility of the psychologist to consider the welfare of those impacted directly and indirectly by their actions, particularly those who are most vulnerable. In order to ensure the wellbeing of clients it is necessary for mental health professionals to develop and maintain competence and knowledge in order to best consider the potential harm and benefit of their actions, to envisage the probability of their occurrence, to act only if they believe the potential for positive impact is greater than the potential for negative impact, and to remediate any negative impact their actions have caused.

When entering into dual relationships mental health professionals should make every effort to:

1. Fully consider all circumstances and restrictions impacting services required by the clients including but not limited to diagnosis, type of treatment, expected length of treatment, closeness of pre-existing relationship, and limitations on confidentiality and privacy (CPA, 2000, II.1, II.2).

2. Engage in self-reflection in order to assess their own comfort level in managing the intersecting relationships successfully (CPA, 2000, II.1, II.2, II.3, II.6, II.8, II.10, II.13, II.14, II.21).

3. Develop a solid foundation of knowledge regarding the benefits and risks of dual relationships prior to entering into and maintaining such relationships, and engage in professional development activities (e.g., reviewing ongoing research, attending workshops/conferences) that contribute to ongoing knowledge development (CPA, 2000, II.6, II.9, IV.3).
4. Ensure the decision-making process has been adequately documented in the treatment records (CPA, 2000, II.19, II.30).

5. Consistently and regularly monitor and document the impact of the dual relationship on the therapeutic alliance (CPA, 2000, II.21, II.22, II.30).

6. Uphold clear boundaries in as many areas as possible/necessary in order to minimize harm and maximize benefit (CPA, 2000, II.21, II.27).

7. Identify alternatives available and provide support in the interim if it is determined that entering into/maintaining a counselling relationship is not possible due to pre-existing relationships (CPA, 2000, II.21, II.31, II.33, II.37).

8. Intervene on behalf of the clients of psychologists who are engaging in/maintaining dual role relationships resultant of boundary violations rather than boundary crossings (CPA, 2000, II.40, II.41, II.49).

Principle III: Integrity in Relationships

Counselling is a change process rooted in the relationship that exists between professional and client. As such, it is no surprise that CAP offers ethical guidelines specific to the responsibility of psychologists to maintain integrity in their professional relationships. The Principle of Integrity in Relationships demands that mental health professionals act in a manner that is open, honest, accurate, straightforward, objective, unprejudiced, and precludes conflicts of interest. When a conflict of interest exists it is the responsibility of the mental health professional to act in the best interests of the client, seeking consultation and implementing safeguards as necessary.

When entering into dual relationships mental health professionals should make every effort to:
1. Consult with supervisor(s)/mentor(s)/colleague(s) and document the consultation in the client’s file (CPA, 2000, III.34, III.38).

2. Provide clients with accurate information regarding the credentials of the supervisor(s)/mentor(s)/colleague(s) acting in a consultatory manner regarding the dual role relationship (CPA, 2000, III.1, III.2, III.5, III.8).

3. Determine that the dual relationship is not exploitative in nature nor contributes to the level of power, perceived or real, that the mental health professional has with respect to the client (CPA, 2000, III.1, III.31).

4. Address the clients’ reactions and feelings in response to the incidental and planned encounters at the next meeting in order to assess and reduce the risk that the dual relationship could disrupt the therapeutic relationship (CPA, 2000, III.34).

5. Discuss with clients a process for resolving conflict resultant of the dual role relationship, including but not limited to objective and open discussion of issues, termination of the pre-existing relationship, and referral to a professional with whom a dual relationship is not a concern (CPA, 2000, III.35).

*Principle IV: Responsibility to Society*

The Principle of Responsibility to Society requires that psychologists act to ensure the well-being of all those who exist in the context in which they work. Additionally, there is the responsibility to ensure that psychological knowledge is utilized to the benefit of society in general. In order to fully understand and affect change to contextual social structures it is necessary for mental health professionals to work collaboratively with others, engage in self-reflection, be receptive to feedback from others, and objectively view and interpret the
impact of existing societal expectations and guiding principles in order to best introduce and implement change.

1. Make knowledge gained regarding dual role relationship management available to other mental health professionals planning to or currently practicing in rural areas and small communities (CPA, 2000, IV.1, IV.3, IV.4, IV.5, IV.11).

2. Engage in self-reflection in order to assess the possible impact the dual relationship will have on the public’s perception of the profession (CPA, 2000, IV.6).

3. Follow and document consistent procedural steps in managing dual role relationships with all clients; review those procedures on a regular basis and incorporate new research and/or ethical standards in order to ensure accountability and maintain high standards of discipline (CPA, 2000, IV.8, IV.9, IV.10).

4. Develop an understanding and knowledge of the community’s perspective on the existence and expectations of dual relationships between professionals of other professions and their clients (CPA, 2000, IV.15, IV.16, IV.17, IV.20).

5. Discuss with members of their family the concept of and issues related to the dual relationships that arise resultant of living and practicing in rural areas and small communities (CPA, 2000, IV.28).
CHAPTER V
Implications, Limitations, and Future Direction

The consensus of those who have worked in rural areas and small communities, and those who monitor practice in those areas, is that while dual relationships at some level are unavoidable the existing ethical guidelines regarding nonsexual dual relationships are vague and ambiguous, leaving it up to mental health professionals to develop their own strategies for managing such relationships. This lack of consistent standards of practice leaves psychologists in a vulnerable position in a society where litigation has become the solution of choice. Evidence suggests that as a result, many mental health professionals work from a position of risk management, a mindset that is based on fear and at the very least may result in clients being denied forms of therapy and interventions they would most benefit from. While knowledge of the professional codes of ethics is essential for ethical practice, being cognizant of these codes is, at times, insufficient. The codes of ethics and codes of conduct of the national and provincial governing bodies of various mental health organizations provide a certain level of guidance; however, they are unable to deal with every situation or answer every question encountered by mental health professionals. The ability to engage in critical thought processes in order to appropriately utilize general codes of ethics in specific challenging situations is a key aspect of psychological practice.

Implications

The guidelines suggested in this project are intended to support mental health professionals practicing in rural areas and small communities, while at the same time increasing their knowledge and accountability, thereby offering protection for consumers. The guidelines promote the development of a strong working alliance, prompt psychologists
to maintain boundaries that ensure confidentiality and privacy are preserved, reduce the reliance on fear-based risk management practices, and contribute to positive counselling outcomes. The intent of this project is to assist mental health professionals in managing the dual role relationships inherent to practice in rural areas and small communities, thereby avoiding ethical dilemmas and providing quality care to clients.

Limitations

Although Canadian psychologists likely encounter ethical dilemmas regarding the management of dual role relationships on a regular basis, little literature exists regarding their experiences. The majority of the literature reviewed regarding dual role relationships came from American and Australian sources. Research regarding ethical dilemmas encountered by Canadian mental health professionals practicing in rural areas and small communities, as well as the current management strategies utilized, is needed. The Ethical Guidelines Regarding Nonsexual Dual Relationships (2008) that are offered in a stand-alone section in Appendix B were developed based on existing literature. However, follow-up is necessary in order to determine their applicability and usefulness in real-life situations.

Future Direction

While this project is intended to act as a support for mental health professionals encountering dual role relationship ethical dilemmas in rural areas and small communities, the development and implementation of further supports would be useful in facilitating the provision of consistent high quality mental health service. One such support would be the implementation of a consultation committee specific to practice in rural areas and small communities. While the ethical guidelines offered in this project strongly encourage mental health professionals to consult with colleagues, the reality is that practice in rural areas and
small communities can, at times, be isolating, making consultation challenging. A consultation committee composed of psychologists knowledgeable and experienced in applying ethical codes to specific situations encountered in rural practice could offer solution to this challenge. A second step in supporting psychologists practicing or planning to practice in rural areas and small communities is the dissemination of information. This could occur in the form of a publication detailing decisions made by ethical committees concerning dual role relationships in rural areas and small communities; as well, graduate-level course work specific to the ethical dilemmas encountered in rural practice would provide psychologists embarking on their career with a strong foundation of knowledge on which to base their ethical decision-making process.

This project provides an overview of the historic and current rends regarding the development of codes of ethics as well as the differing positions on the ethical management of dual role relationships. From the evidence identified in the review of the literature, this author has offered ethical guidelines based on the principles set forth by the Canadian Psychological Association Code of Ethics (2000). As the guidelines set forth in this project have not yet been tested, their effectiveness is yet to be determined. However, the literature review portion of this project firmly supports the need for clear and consistent ethical guidelines specific to managing dual role relationships inherent to practice in rural areas and small communities. Despite the limitations that have been discussed, this project can be seen as an important step in providing mental health professionals with guidelines intended to increase knowledge and accountability.
References


Appendix A

Relevant Standards from the Canadian Code of Ethics for Psychologists in Support of the
Ethical Guidelines for Entering into and Managing Dual Role Ethical Relationships

<table>
<thead>
<tr>
<th>I. Respect for the Dignity of Persons</th>
<th>II. Responsible Caring</th>
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<td>Competence and Self-Knowledge (II.6, 8, 9, 10)</td>
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<td>Extended Responsibility (II.49)</td>
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Principle I: Respect for the Dignity of Persons

*General Respect*
I.1 Demonstrate appropriate respect for the knowledge, insight, experience, and areas of expertise of others.

*Fair Treatment/Due Process*
I.12 Work and act in a spirit of fair treatment to others.

*Informed Consent*
I.16 Seek as full and active participation as possible from others in decisions that affect them, respecting and integrating as much as possible their opinions and wishes.

I.17 Recognize that informed consent is the result of a process of reaching an agreement to work collaboratively, rather than of simply having a consent form signed.

I.19 Obtain informed consent from all independent and partially dependent persons for any psychological services provided to them...

I.21 Establish and use signed consent forms that specify the dimensions of informed consent or that acknowledge that such dimensions have been explained and are understood, if such forms are required by law or if such forms are desired by the psychologist, the person(s) giving consent, or the organization for whom the psychologist works.

I.23 Provide, in obtaining informed consent, as much information as reasonable or prudent persons would want to know before making a decision or consenting to the activity. The psychologist would relay this information in language that the persons understand … and would take whatever reasonable steps are needed to ensure that the information was, in fact, understood.

I.24 Ensure, in the process of obtaining informed consent, that at least the following points are understood: purpose and nature of the activity; mutual responsibilities; confidentiality protections and limitations; likely benefits and risks; alternatives; the likely consequences of non-action; the option to refuse or withdraw at any time, without prejudice; over what period of time the consent applies; and, how to rescind consent if desired.

*Freedom of Consent*
I.27 Take all reasonable steps to ensure that consent is not given under conditions of coercion, undue pressure, or undue reward.

*Protections for Vulnerable Persons*
I.33 Seek to use methods that maximize the understanding and ability to consent of persons of diminished capacity to give informed consent, and that reduce the need for a substitute decision maker.
I.34 Carry out informed consent processes with those persons who are legally responsible or appointed to give informed consent on behalf of persons not competent to consent on their own behalf, seeking to ensure respect for any previously expressed preferences of persons not competent to consent.

I.36 Be particularly cautious in establishing the freedom of consent of any person who is in a dependant relationship to the psychologist (e.g., student, employee). This may include but is not limited to, offering that person an alternative activity to fulfill their educational or employment goals, or offering a range of research studies or experience opportunities from which the person can select, none of which is so onerous as to be coercive.

Principle II: Responsible Caring

*General Caring*

II.1 Protect and promote the welfare of clients, research participants, employees, supervisees, students, trainers, colleagues, and others.

II.2 Avoid doing harm to clients research participants, employees, supervisees, students, trainers, colleagues, and others.

II.3 Accept responsibility for the consequences of their actions.

*Competence and Self-Knowledge*

II.6 Offer to carry out (without supervision) only those activities for which they have established their competence to carry them out to the benefit of others.

II.8 To take immediate steps to obtain consultation or to refer a client to a colleague or other appropriate professional, whichever is more likely to result in providing the client with competent service, if it becomes apparent that a client’s problems are beyond their competence.

II.9 Keep themselves up to date with a broad range of relevant knowledge, research methods, and techniques, and their impact on persons and society, through the reading of relevant literature, peer consultation, and continuing education activities, in order that their service or research activities and conclusions will benefit and not harm others.

II.10 Evaluate how their own experiences, attitudes, beliefs, values, social context, individual differences, specific training, and stresses influence their interactions with others, and integrate this awareness into all efforts to benefit and not harm others.

*Risk/Benefit Analysis*
II.13 Assess the individuals, families, groups, and communities involved in their activities adequately enough to ensure they will be able to discern what will benefit and not harm the persons involved.

II.14 Be sufficiently sensitive to and knowledgeable about individual, group, community, and cultural differences and vulnerabilities to discern what will benefit and not harm persons involved in their activities.

Maximize Benefits
II.19 Create and maintain records relating to their activities that are sufficient to support continuity and appropriate coordination of their activities with the activities of others.

II.21 Strive to provide and/or obtain the best possible service for those needing and seeking psychological service.

II.22 Monitor and evaluate the effect of their activities, record their findings, and communicate new knowledge relevant to others.

Minimize Harm
II.27 Be acutely aware of the power relationship in therapy and, therefore, not encourage or engage in sexual intimacy with therapy clients, neither during therapy, nor for that period of time following therapy during which the power relationship reasonably could be expected to influence the clients’ personal decision making.

II.30 Be acutely aware of the need for discretion in the recording and communication of information, in order that the information not be misinterpreted or misused to the detriment of others. This includes, but is not limited to: not recording information that could lead to misinterpretation and misuse; avoiding conjecture; clearly labelling opinion; and, communicating information in language that can be understood clearly by the recipient of the information.

II.31 Give reasonable assistance to secure needed psychological services or activities, if personally unable to meet requests for needed psychological services or activities.

II.33 Maintain appropriate contact, support, and responsibility for caring until a colleague or other professional begins service, if referring a client to a colleague or other professional.

Offset/Correct Harm
II.37 Terminate an activity when it is clear the activity carries more than minimal risk of harm and is found to be more harmful than beneficial, or when the activity is no longer needed.

II.40 Act to stop or offset the consequences of seriously harmful activities being carried out by another psychologist or member of another discipline, when there is objective information about the activities and the harm, and when these activities have come to
their attention outside of a confidential client relationship between themselves and the psychologist or member of another discipline. This may include reporting to the appropriate regulatory body, authority, or committee for action, depending on the psychologist’s judgment about the person (s) or body (ies) best suited to stop or offset the harm, and depending on regulatory requirements and definitions of misconduct.

II.41 Act also to stop or offset the consequences of harmful activities carried out by another psychologist or member of another discipline, when the harm is not serious or the activities appear to be primarily a lack of sensitivity, knowledge, or experience, and when the activities have come to attention outside of a confidential client relationship between themselves and the psychologist or member of another discipline. This may include talking informally with the psychologist or member of another discipline, obtaining objective information and, if possible and relevant, the assurance that the harm will be discontinued and corrected. If in a vulnerable position (e.g., employee, trainee) with respect to the other psychologist or member of another discipline, it may include asking persons in less vulnerable positions to participate in the meeting (s).

Extended Responsibility
II.49 Encourage others, in a manner consistent with this Code, to care responsibly.

Principle III: Integrity in Relationships

Accuracy/Honesty
III.1 Not knowingly participate in, condone, or be associated with dishonesty, fraud, or misrepresentation.

III.2 Accurately represent their own and their colleagues credentials, qualifications, education, experience, competence, and affiliations, in all spoken, written, or printed communications, being careful not to use descriptions or information that could be misinterpreted (e.g., citing membership in a voluntary association of psychologists as testament of competence).

III.5 Accurately represent their own and their colleagues activities, functions, contributions, and likely or actual outcomes of their activities (including research results) in all spoken, written, or printed communication.

III.8 Acknowledge the limitations of their own and their colleagues’ knowledge, methods, findings, interventions, and views

Avoidance of Conflict of Interest
III.31 Not exploit any relationship established as a psychologist to further personal, political, or business interests at the expense of the best interests of their clients, research participants, students, employers, or others.

III.34 Manage dual or multiple relationships that are unavoidable due to cultural norms or other circumstances in such a manner that bias, lack of objectivity, and risk of
exploitation are minimized. This might include obtaining ongoing supervision or consultation for the duration of the dual or multiple relationship, or involving a third party in obtaining consent (e.g., approaching a client or employee about becoming a research participant).

III.35 Inform all parties, if a real or potential conflict of interest arises, of the need to resolve the situation in a manner that is consistent with Respect for the Dignity of Persons (Principle I) and Responsible Caring (Principle II), and take all reasonable steps to resolve the issue in such a manner.

Reliance on the Discipline
III.38 Seek consultation from colleagues and/or appropriate groups and committees, and give due regard to their advice in arriving at a responsible decision, if faced with difficult situations.

Principle IV: Responsibility to Society

Development of Knowledge
IV.1 Contribute to the discipline of psychology and of society’s understanding of itself and human beings generally, through free enquiry and the acquisition, transmission, and expression of knowledge and ideas, unless such activities conflict with other basic ethical requirements.

IV.3 Keep informed of progress in their area(s) of psychological activity, take this progress into account in their work, and try to make their own contributions to this progress.

Beneficial Activities
IV.4 Participate in and contribute to continuing education and the professional and scientific growth of self and colleagues.

IV.5 Assist in the development of those who enter the discipline of psychology by helping them to acquire a full understanding of their ethical responsibilities, and the needed competencies of their chosen area(s), including and understanding of critical analysis and the variations, uses, and possible misuses of the scientific paradigm.

IV.6 Participate in the process of critical self-evaluation of the discipline’s place in society, and in the development and implementation of structures and procedures that help the discipline to contribute to beneficial societal functioning and changes.

IV.8 Engage in regular monitoring, assessment, and reporting … of their ethical practices and safeguards.

IV.9 Help develop, promote, and participate in accountability processes and procedures related to their work.
IV.10 Uphold the discipline’s responsibility to society by promoting and maintaining the highest standards of the discipline.

IV.11 Protect the skills, knowledge, and interpretations of psychology from being misused, used incompetently, or made useless … by others.

Respect for Society
IV.15 Acquire an adequate knowledge of the cultural, social structure, and customs of a community before beginning any major work there.

IV.16 Convey respect for, and abide by prevailing community mores, social customs, and cultural expectations in the ir scientific and professional activities, provided that this does not contravene any of the ethical principles of this Code.

IV.17 Familiarize themselves with the laws and regulations of the societies in which they work, especially those that are related to their activities as psychologists, and abide by them. If those laws or regulations seriously conflict with the ethical principles contained herein, psychologists would do whatever they could to uphold the ethical principles….

Development of Society
IV.20 Be sensitive to the needs, current issues, and problems of society ….

IV.28 Provide the public with any psychological knowledge relevant to the public’s informed participation in the shaping of social policies and structures, if they possess expert knowledge that bears on the social policies and structures.
Appendix B

Ethical Guidelines Regarding Nonsexual Dual Role Relationships

The ethical guidelines suggested in this section are founded on general principles derived from the *Canadian Code of Ethics for Psychologists* (CPA, 2000). The recommendations are organized around the four principles that form the structure of the *Code*, namely Principle I: Respect for the Dignity of Persons, Principle II: Responsible Caring, Principle III: Integrity in Relationships, and Principle IV: Responsibility to Society. This application of the ethical principles set forth by the *Code* is specific to entering into and managing dual relationships in rural areas and small communities.

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must strive to act in a manner that demonstrates their ability to maintain healthy boundaries with clients while functioning in an environment that makes it difficult if not impossible to avoid dual relationships in some form. When dual relationships are present psychologists need to acknowledge their existence and avoid exploitation based on knowledge gained of the client resultant of either relationship. In working collaboratively with the client and through the process of informed consent mental health professionals will explain the concept of dual relationships and discuss potential positive and negative impact on privacy and confidentiality, working alliance, and counselling outcomes.

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2. Utilize an informed consent document that clearly delineates the benefits and risks inherent to dual role relationships, including potential limitations to confidentiality and privacy (CPA, 2000, I.1, I.12, I.16, I.17, I.21, I.23, I.24, I.27).

3. When working with children and clients of diminished capacity, ensure that the concept and potential impact of dual relationships inherent to practice in rural areas and small communities is discussed with the client as well as with parents/guardians to ensure informed consent is obtained (CPA, 2000, I.12, I.16, I.17, I.19, I.21, I.23, I.24, I.33, I34).

_Principle II: Responsible Caring_
The Principle of Responsible Caring requires that, in the very least, the actions of mental health professionals will lead to no harm and, rather, be of benefit to others. It is the responsibility of the psychologist to consider the welfare of those impacted directly and indirectly by their actions, particularly those who are most vulnerable. In order to ensure the wellbeing of clients it is necessary for mental health professionals to develop and maintain competence and knowledge in order to best consider the potential harm and benefit of their actions, to envisage the probability of their occurrence, to act only if they believe the potential for positive impact is greater than the potential for negative impact, and to remediate any negative impact their actions have caused.

When entering into dual relationships mental health professionals should make every effort to:

1. Fully consider all circumstances and restrictions impacting services required by the clients including but not limited to diagnosis, type of treatment, expected length of treatment, closeness of pre-existing relationship, and limitations on confidentiality and privacy (CPA, 2000, II.1, II.2).

2. Engage in self-reflection in order to assess their own comfort level in managing the intersecting relationships successfully (CPA, 2000, II.1, II.2, II.3, II.6, II.8, II.10, II.13, II.14, II.21).

3. Develop a solid foundation of knowledge regarding the benefits and risks of dual relationships prior to entering into and maintaining such relationships, and engage in professional development activities (e.g., reviewing ongoing research, attending workshops/conferences) that contribute to ongoing knowledge development (CPA, 2000, II.6, II.9, IV.3).
4. Ensure the decision-making process has been adequately documented in the treatment records (CPA, 2000, II.19, II.30).

5. Consistently and regularly monitor and document the impact of the dual relationship on the therapeutic alliance (CPA, 2000, II.21, II.22, II.30).

6. Uphold clear boundaries in as many areas as possible/necessary in order to minimize harm and maximize benefit (CPA, 2000, II.21, II.27).

7. Identify alternatives available and provide support in the interim if it is determined that entering into/maintaining a counselling relationship is not possible due to pre-existing relationships (CPA, 2000, II. 21, II.31, II.33, II.37).

8. Intervene on behalf of the clients of psychologists who are engaging in/maintaining dual role relationships resultant of boundary violations rather than boundary crossings (CPA, 2000, II.40, II.41, II.49).

Principle III: Integrity in Relationships

Counselling is a change process rooted in the relationship that exists between professional and client. As such, it is no surprise that CAP offers ethical guidelines specific to the responsibility of psychologists to maintain integrity in their professional relationships. The Principle of Integrity in Relationships demands that mental health professionals act in a manner that is open, honest, accurate, straightforward, objective, unprejudiced, and precludes conflicts of interest. When a conflict of interest exists it is the responsibility of the mental health professional to act in the best interests of the client, seeking consultation and implementing safeguards as necessary.

When entering into dual relationships mental health professionals should make every effort to:
1. Consult with supervisor(s)/mentor(s)/colleague(s) and document the consultation in the client’s file (CPA, 2000, III.34, III.38).

2. Provide clients with accurate information regarding the credentials of the supervisor(s)/mentor(s)/colleague(s) acting in a consultatory manner regarding the dual role relationship (CPA, 2000, III.1, III.2, III.5, III.8).

3. Determine that the dual relationship is not exploitative in nature nor contributes to the level of power, perceived or real, that the mental health professional has with respect to the client (CPA, 2000, III.1, III.31).

4. Address the clients’ reactions and feelings in response to the incidental and planned encounters at the next meeting in order to assess and reduce the risk that the dual relationship could disrupt the therapeutic relationship (CPA, 2000, III.34).

5. Discuss with clients a process for resolving conflict resultant of the dual role relationship, including but not limited to objective and open discussion of issues, termination of the pre-existing relationship, and referral to a professional with whom a dual relationship is not a concern (CPA, 2000, III.35).

**Principle IV: Responsibility to Society**

The Principle of Responsibility to Society requires that psychologists act to ensure the well-being of all those who exist in the context in which they work. Additionally, there is the responsibility to ensure that psychological knowledge is utilized to the benefit of society in general. In order to fully understand and affect change to contextual social structures it is necessary for mental health professionals to work collaboratively with others, engage in self-reflection, be receptive to feedback from others, and objectively view and interpret the
impact of existing societal expectations and guiding principles in order to best introduce and implement change.

1. Make knowledge gained regarding dual role relationship management available to other mental health professionals planning to or currently practicing in rural areas and small communities (CPA, 2000, IV.1, IV.3, IV.4, IV.5, IV.11).

2. Engage in self-reflection in order to assess the possible impact the dual relationship will have on the public’s perception of the profession (CPA, 2000, IV.6).

3. Follow and document consistent procedural steps in managing dual role relationships with all clients; review those procedures on a regular basis and incorporate new research and/or ethical standards in order to ensure accountability and maintain high standards of discipline (CPA, 2000, IV.8, IV.9, IV.10).

4. Develop an understanding and knowledge of the community’s perspective on the existence and expectations of dual relationships between professionals of other professions and their clients (CPA, 2000, IV.15, IV.16, IV.17, IV.20).

5. Discuss with members of their family the concept of and issues related to the dual relationships that arise resultant of living and practicing in rural areas and small communities (CPA, 2000, IV.28).