# 8

# Nonsexual Multiple-Role Relationships

Good habits result from resisting temptation.

Ancient proverb

Ethics complaints based on sexual and nonsexual role blurring comprise the most frequent type of complaint brought to the ethics committee of the American Psychological Association (APA; Knapp, Bennett, & VandeCreek, 2012) and a common category of licensing board actions (Bader, 1994; Knapp, Younggren, VandeCreek, Harris, & Martin, 2013; Montgomery & Cupit, 1999; Neukrug, Milliken, & Walden, 2001; Sonne, 1994).

Sexual intimacies with current clients are considered unethical under any circumstances. However, ethics codes reveal relaxed admonitions from earlier mandates that essentially forbade virtually any boundary crossing with psychotherapy clients (APA: 3.05, 7.04; American Association for Marriage and Family Therapy [AAMFT]: 1.3, 1.7, 4.6; American Counseling Association [ACA]: A.6; National Association of Social Workers [NASW]: 1.06, 3.01). Debates do continue regarding the point at which a boundary crossing becomes a boundary violation. Views continue to remain divergent, ranging from avoiding interactions or discourse falling outside therapeutic issues to treatment orientations that almost obliterate the difference between "therapist" and "good buddy." The addition of individual clients' tolerance for a boundary crossing further complicates the matter, as seen in the first case.

**Case 8–1:** Melvin Chatty, Ph.D., maintained a therapy style that involves frequent revelations about his own life struggles and triumphs that paralleled those of a client, believing such sharing deepened the therapeutic alliance and proved to clients that such issues can be successfully resolved. Charlie Splitup found the story of Dr. Chatty's divorce helpful in managing his own quest to become happily single again. Alice Fears found his recollections of moving from a small town to a large city reassuring and comforting. Dr. Chatty's personal stories about his own problem with alcohol in his youth made Gin Jumpy uncomfortable, and Buck Waste quit therapy with Dr. Chatty after three sessions because he talked too much about himself.

A too rigid stance with regard to boundaries may deprive clients in ways that are counter to their treatment needs (Barnett, 2014). However, when a client experiences a boundary crossing as uncomfortable or unwanted, it is probably a boundary violation. If it causes an individual client harm, it is definitely a boundary violation (Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007). This means that considerable demands are placed on competent, individualized decision making for each treatment dyad (Gottleib & Younggren, 2009).

It is instructive to point out how entering into a complex multiple-role relationship can feel so right at the time, with no hint of how it could eventually unravel like a cheap sweater. As an example, writer Susan Shapiro and her long-time, greatly admired psychotherapist decided to create a book together. He would supply the material, and she would do the writing. She was not paid for her service, and he did not charge his usual $200 a session for therapy. Royalties would be split 50/50, and the authorship would have his name first followed by "with Susan Shapiro." It seemed like a win–win proposition at the time. However, as Shapiro began to learn more of her therapist's very private life, she came to believe he was sabotaging the project, perhaps because of his own issue with a parent resulting in a fear of success. On confronting him—almost as a therapist would confront a client—the relationship began to stall and dissolve. Shapiro experienced feelings of rejection and abandonment. After a series of back-and-forth jousting, the book was ultimately published. But, the psychological costs seemed higher than any monetary benefit (Shapiro, 2011).

## BOUNDARIES AND MULTIPLE ROLES

Boundaries can range from crisp to fuzzy. Boundary blurring can be formed intentionally or arise unexpectedly and can readily involve conflicts of interest (Ebert, 2006). Some boundary crossings prove beneficial to clients and do not even necessarily create a multiple-role relationship. Limited or inconsequential contacts

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growing out of chance meetups with clients would not normally fall under the definition or cause any ethical concerns, although we illustrate how unexpected encounters can be awkward and may require some fast decision making. Other boundary breaks are extremely harmful, depending largely on the context intent of the therapist.

Multiple-role relationships with clients and students are viewed as unethical when objectivity is compromised, competence degrades, effectiveness in performing professional functions could become impaired, or if a risk of exploitation might result (APA: 3.05; AAMFT: 1.3, 4.1; ACA: A.6; NASW: 1.06, 3.01, 3.02). The APA defines multiple-role relationships as occurring when a therapist is already in a professional role with a person while in another role with the same person, is in a relationship with someone closely associated with or related to the person, or makes promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

To qualify under the APA definition, the initial relationship typically requires an established connectedness between the parties. The primary role is usually with an ongoing therapy client, although it could be with another significant individual, such as a client's family member or close relation. Nonsexual consecutive role relationships with *ex*-clients do not fall under any specific prohibitions. However, based on the posttherapy incidents we describe, caution is advised even after a natural termination of the professional role (see NASW 1.06.c).

Some boundary crossings are difficult to define and evaluate. For example, just as some dentists may sell electric toothbrushes or audiologists sell hearing aids to their patients, mental health professionals may have books, tapes, videos, or other therapeutic aids available for clients to purchase. Such products may be beneficial, but clients may find it difficult to resist a sales pitch from their therapist/vendor, especially for those promoting products created by the therapist. Although not strictly forbidden, the slope is slippery, and the related ethical issues can be debated (Sommers-Flanagan, 2012).

## DIFFERING VIEWS ON NONSEXUAL BOUNDARIES

Those mental health professionals who decry the concept of boundaries argue that maintaining rigid roles promotes psychotherapy as a mechanical application rather than relating to clients as unique persons. Such rigid, cold, and aloof "cookbook therapy," they say, harms the formation of empathy and stunts the natural process of psychotherapy. Instead, acting as a fully human therapist provides the most constructive way to enhance personal connectedness and honesty in therapeutic relationships (Hedges, 1993) and may even improve professional judgment (Tomm, 1993). Lazarus (1994) put it bluntly: "Practitioners who hide behind rigid boundaries, whose sense of ethics is uncompromising, will, in my opinion, fail to really help many of the clients who are unfortunate enough to consult them" (p. 253). Those who criticize drawing firm boundaries further assert that role complexities are inevitable, and attempting to control them by invoking authority (e.g., through ethics codes) oversimplifies the ramifications inherent in the psychotherapy process and creates the practice of defensive therapy (Bograd, 1993; Clarkson, 1994; Lazarus & Zur, 2002; Ryder & Hepworth, 1990).

Because ethics codes now specify fewer specific restrictions, mental health professionals may feel empowered to make role-blending judgments based on the *likelihood* that exploitation or harm reasonably might or might not occur. Such decisions emerge from the context of the therapy, not a list of rules (Zur, 2014). Although we certainly agree that careful consideration must precede softening of boundaries, accurate outcome predictions are hardly guaranteed. Furthermore, boundaries that are more lax might place the unaware therapist at far greater risk than earlier, stricter rules. Why? "Exploitation" and "harm" are general terms, somewhat vague, and open to interpretation. Therefore, any client who claims exploitation or harm when roles became complicated could be difficult to challenge and refute. Ethics committees, licensing boards, and juries will make those findings on a case-by-case basis. The

takeaway message here is that any boundary crossing or multiple-role formation should be documented regarding what was decided and why should it ever become necessary to explain a deviation from a relationship focused strictly and objectively on the client (see ACA: A.6.c).

Our stand on role blending is somewhat conservative given the harms ill-conceived decisions can cause clients as well as therapists. We do recognize the impossibility of avoiding all nonprofessional interactions with clients and acknowledge the futility of setting firm boundaries appropriate for every client under every circumstance. However, we agree with Pope's (1991) contention that the therapeutic relationship should be secured within a reliable set of boundaries that both therapists and clients can depend on. Similarly, Knapp and VandeCreek (2006) asserted that boundaries create a safe atmosphere that allows a relationship to develop without worrying about the needs of the therapist. Borys (1994) noted that clear and consistent boundaries may constitute a curative factor in and of itself. In short, the therapy relationship should remain a sanctuary in which clients can focus on themselves and their needs while receiving clean feedback and guidance.

All intentional decisions to blur roles require sound clinical judgment indicating clearheaded self-awareness of one's motives, an assessment of how the client would benefit, and any foreseeable consequences. A consideration of cultural differences is also essential. Pack-Brown and Williams (2003) suggested multiple-role relationships, as proscribed in professional ethics codes, reveal Eurocentric values (e.g., distance over closeness, detachment over attachment, and objectivity over influence), which results in a "cultural bias toward bounded rather than fluid relationships" (p. 148). We would not suggest that therapists violate ethical codes because a client's culture would find adding another role acceptable or even desirable, but a full understanding of cultural differences, how they manifest themselves, and the ability to communicate effectively with clients are essential groundings for a successful therapeutic alliance (see Chapter 5).

For therapists already predisposed to blend roles, rationalization processes are probably well under way, thus subverting the accuracy of any personal risk assessment. One can even rationalize inappropriate role blending as benevolent or therapeutic. As Gabbard (1994) concluded: "Because the needs of the psychotherapist often get in the way of the therapy, the mental health professions have established guidelines . . . that are designed to minimize the opportunity for therapists to use their patients for their own gratification" (p. 283).

We must face an unfortunate reality: Psychotherapy provides an almost-ideal climate—a "perfect storm" if you will—for emotionally or morally precarious mental health professionals to seek to gratify their personal needs. The settings are private and intimate. The authority falls on the side of the therapist. And, if things turn sour, the therapist can eliminate the relationship by unilaterally terminating it. While reviewing the cases in this chapter, do note the pervasive incidence of harm perpetrated by therapists who were, themselves, out of touch with the impact of their judgments about those they were supposed to be helping.

## CAUTIONS

Perhaps the most difficult message for us to convey in writing is how *right* it might feel at the time to slip into a more complex role with clients. Our brief case stories summarize situations that often take weeks and months to unfold. One needs to pay attention to warning signs. (See Chapter 17 for a detailed list of red flags.)

We also need to stress the importance of assessing how venturing into crossing a boundary is perceived by clients. The exact same content may elicit exceedingly different interpretations (Pope & Keith-Spiegel, 2008). The intent of one party and the impact on another are not always congruent. For example, a male therapist in his 40s says to a young female client who enters the office for her second session, "My, my. Don't you look gorgeous today!" A client could construe what was meant as a simple compliment as flirtatious, maybe embarrassing,

or even harassing. But, if the therapist is a married 68-year-old proud grandfather of six who has been seeing the client for 6 months, it is unlikely that the same remark would come across as anything other than benign or supportive.

### Risky Therapists

Therapists with underdeveloped competencies or poor training can sometimes be more prone to improper role blending. However, even those with excellent training and high levels of competence may relate unacceptably to those with whom they work because their own boundaries are not firm or they feel a need for adoration, power, or social connection.

### Self-Disclosing Therapists

Therapists cannot help but disclose some personal information. Choices, such as mode of dress, office décor, preferences for how clients should address them, speech mannerisms (e.g., the use of profanity), and scores of other visual and vocal clues will inform clients beyond the more obvious age, gender, voice characteristics, and professional credentials. Most of the time, more purposeful disclosing has no clear ethical implications, although Knapp, VandeCreek, et al. (2013) discussed how what they call "behaviors on the ethical rim" may unintentionally interfere with client expectations for successful therapy and perceptions of competence.

How much, what, and under what circumstances therapists should disclose personal information about themselves has been a heated topic of interest (e.g., Bloomgarden & Mennuti, 2009; Bridges, 2001; Cristelle, 2011; Farber, 2006; Goldstein, 1997; Striker & Fisher, 1990; Zur, 2007). Some hold the position that therapists should share only professionally related information. But, most mental health professionals apparently do knowingly self-disclose, at least on occasion (C. E. Hill & Knox, 2001; Pope, Tabachnik, & Keith-Spiegel, 1987; Yeh & Hayes, 2011). The question, then, is not related to if but to how, when, why, and what.

Self-disclosures can be benign and helpful (Knapp & VandeCreek, 2006), and many studies have examined the role played by self-disclosure in the process of therapy (e.g., Davis, 2002; Farber, Berano, & Capobianco, 2004; Kim et al., 2003; Z. D. Peterson, 2002). Therapist visibility can increase the connection with the client and affords marginalized clients more power in the relationship (Vasquez, 2007). However, those who engage in considerable and revealing self-referencing stand at greater risk for forming problematic relationships with clients. Whereas well-considered illustrations from the therapist's life may help make a point or signal empathy, absorbing therapy time with extended renditions of one's own personal history and family issues is not typically justifiable.

**Case 8–2:** Harvard Strutter, Ph.D., looked forward to sessions with Lois Teem, a young client struggling with the demands of college life, feeling insecure and unprepared. Strutter relished telling his own stories of success as an undergraduate, thinking they would inspire Ms. Teem. Strutter was taken aback when Ms. Teem complained to the counseling center director about his "bragging" taking up most of every session and making her feel even more deficient.

Those favoring appropriate self-disclosures in therapy assert that more authentic alliances can be created, that clients can better understand how everyone has failings and insecurities, and that therapeutic engagements can be strengthened. Furthermore, new insights and perspectives may free clients to disclose difficult and shameful material (Bridges, 2001; Curtis & Hodge, 1994; Z. D. Peterson, 2002; Williams, 2009; Zur, 2007). But, such disclosures can go only so far,

**Case 8–3:** Matt Dillinger, M.D., decided to share his fantasy with a client who was feeling anxious about the extent of her rage toward her ex-husband. Dillinger revealed his intense dislike of a colleague and how he enjoyed imagining himself "tracking him down and shooting him in the street like a dirty dog." The client was stunned by Dr. Dillinger's bizarre fantasy and never returned.

Concerns center on intentional self-disclosures for the purpose of gratifying the

needs or desires of the therapist, that burden or confuse clients, or are excessive or unwelcomed (C. E. Hill & Knox, 2001; Keith-Spiegel, 2014; Zur, 2007). Contextual issues are important; these include the therapist's theoretical orientation and treatment approaches as well as client factors, such as culture, gender, mental health history, current treatment needs, and agreed-on goals. However, even though becoming too relaxed when sharing one's own personal life (or ignoring unexpected client reactions to disclosures) may not result in a formal ethics charge, effective psychotherapy can be compromised (Barnett, 2011),

Clients, of course, may instigate inquiries into their therapists' personal lives. It seems reasonable to expect they would want to know about the person in whom they are placing considerable trust. So, we agree with Lazarus's (1994) contention that it feels demeaning to have an inquisitive client's question dismissed by responding with another question: "Do you have children, Dr. Shell?" "Why do you ask me, Maurice?" Not all clients' questions should be answered, of course, and it may prove wise to explore the intent of a client who is too curious. Skillful therapists can respond without demeaning their clients while reserving the right to consider their own level of comfort (Barnett, 2011; Goldstein, 1997).

Of course, clients can obtain answers to at least some of their questions without ever asking directly. Internet searches can turn up highly personal information, even when therapists are careful not to participate in social media and actively attempt to keep a low profile on the Internet. (More about these issues, including therapists trolling for information about clients, is discussed in Chapters 6 and 11.)

**Case 8–4:** Bernard Public, Ph.D., accepts any friendship offer on Facebook. His family as well as his clients have been "friended" and can view his entire wall. He posts photos of his children, wife, home, and office and shares stories about his travels and hobbies. When a client entered an irrelevant comment complaining about something Dr. Public said during a session, everyone else chimed in, mostly to defend Dr. Public and accuse the poster of being mean and "a loser." The client felt humiliated and attempted to press an ethics complaint. Dr. Public maintained that he never discussed psychotherapy or his clients and only wanted his clients to see him as a normal human being just like themselves. He had not anticipated getting into this kind of pickle.

Although an ethics committee did not find Dr. Public guilty of an ethics violation, they strongly suggested he rethink his Facebook privacy settings and the wisdom of giving clients that much access to his private affairs.

### Professional Isolation

Professional or personal isolation conspires to cloud professional judgment and decision making (Cooper, 2009). The therapist described in the next case might elicit sympathy were it not for her ill-conceived approach to coping with her own unmet needs.

**Case 8–5:** Ima Lonely, Ph.D., an unhappy divorced mother of two adult children who lived hundreds of miles away, maintained her practice in the living room of her home. She often served wine and appetizers after the therapy session and sometimes invited herself along on clients' social outings. She appeared to keep a string of perennial clients to provide her with a sense of family. Eventually, a client complained about her excessive intrusion into his family's life.

During ethics committee meetings, we could not help but notice how many cases involving boundary blurring (including sexual ones) occurred among therapists who maintained solo practices, often in remote offices removed from other mental health professionals. Something about therapists either choosing to work in isolation or the isolating conditions themselves appears to cloud the maintenance of professional standards of care. Regardless of the reason, an insular practice with no provisions for ongoing professional contact diffuses professional identity, especially given that it is not difficult to find ways to engage in collegial support.

Examples include peer supervision groups, consultation, participation in professional associations, continuing professional education programs, and Internet news and chat groups.

### Therapeutic Orientation and Specialty Practices

Some therapists practicing according to types of orientations are likely more vulnerable to charges of boundary violations. Simon's (1988) research, for example, revealed how therapist self-disclosure differed significantly depending on whether psychotherapy is practiced as a process working through the clients' transference or on the interconnections between client and therapist. Williams (1997) noted that adherents of humanistic and encounter group philosophies based on tearing down interpersonal boundaries often disclose a great deal about themselves, hug their clients, and insist on the use of first names. These therapists become, according to Williams, more vulnerable to ethics complaints even though they are practicing according to their training.

Some therapists who specialize with a particular clientele or in certain venues may need to exercise extra vigilance because they can be conducive to (or even require) relaxed boundaries. Sports psychologists, for example, often travel, eat, and "hang out" with a team and may be called on to fill water bottles and help out with whatever else needs doing (M. B. Anderson, Van Raalte, & Brewer, 2001). A more complex relationship exists for mental health professionals placed in military units, where quarters are close and they, unlike embedded journalists, are expected to tend to the unit's needs and even engage in combat (Johnson, Ralph, & Johnson, 2005). In such instances, murky edges may be inherent in the nature of practice rather than inappropriate.

Pastoral counseling, by which the therapist may also function as the client's religious guide, presents a particularly sensitive preexisting dual role.

**Case 8–6:** Mildred Devine requested counseling from her minister, Luther Pew, for what she termed a "spiritual crisis"; Pew also held a license in marriage and family therapy. Ms. Devine relayed her uncertainties, blaming God for having forsaken her. Rev. Pew responded by disclosing his own questioning of faith and shared some crises he was coping within his own family. Miss Devine became upset by these revelations, passed them along to other parishioners, and left the church. Several weeks later, she made a suicide attempt and required hospitalization.

Reverend Pew appears to have mismanaged his parishioner's clinical depression by misjudging its intensity and his own lack of competence to treat it. He also interjected too much from his life while failing to recognize Ms. Devine's request for spiritual guidance, not her minister's confessions. Pew should have stuck to his role as a pastor and referred Ms. Devine to someone competent to treat her depression.

### Risky Career Periods for Inappropriate Role Blending

Therapists who engage in inappropriate role blending are often inexperienced. Many have come from graduate programs in which students developed complex relationships with their educators and supervisors. Similarly, the internship or residency period usually involves multiple roles, including social, evaluative, and business-related activities (Slimp & Burian, 1994; see also Chapter 10). Mental health professionals new to functioning independently may have had insufficient opportunity to observe other professionals with appropriate boundaries in place. Further, some therapists have experienced appalling supervisory models, involving sexual advances and other improper behaviors, when they were students, which could missocialize them even before they begin to practice independently (Glaser & Thorpe, 1986; Pope, Levenson, & Schover, 1980).

Other early career therapists may be overly eager to do everything right and make no mistakes, which could lead to an unhealthy risk-avoidance posture. Unless such therapists can become comfortable with their role, they may become inflexible and face

difficulties engaging clients in meaningful ways (Behnke, 2009).

The midcareer period can be risky for therapists whose profession or life in general has not panned out according to the dreams of their youth. Therapy may feel less involving and more routine. Divorce or other family-based dysfunction, onset of a chronic illness, and apprehension about aging are among other midcareer difficulties that can interfere with professional judgment. The majority of therapists who engage in sexual relationships with their clients are middle-aged.

Another elevated risk period occurs at the far end of the career cycle. Sometimes, older therapists have, perhaps without full awareness, come to see themselves as evolved beyond questioning and bestow on themselves a "senior pass" to do whatever they please.

**Case 8–7:** Reddy Beenthere, Ph.D., just celebrated 40 years in practice. He quit trying to keep up with the professional literature long ago. Because of his professional longevity, he believed therapy just came naturally to him without putting in much thought. An ongoing client brought in a friend with whom she was experiencing significant conflicts for a joint session. The session went poorly, with loud accusations between the client and her friend. Nevertheless, Beenthere liked the friend, who shared his own interest in jazz, so he called the friend right after the contentious session to invite him to meet at a jazz bar for drinks. Additional social meetings followed. The client discovered the liaisons, felt betrayed, quit therapy, and filed a complaint.

**Case 8–8:** Gloria Vast, Ph.D., refers to herself as the "grand dame of psychology." For many years, she has run encounter groups based on her long-standing best-selling book, *Touch Yourself, Touch the Universe*. Now in her late 60s, she pays several of her current clients minimum wage to assist her. Should her client–workers become disaffected, she berates them and sometimes banishes them. One client expelled from the circle successfully pressed charges of exploitation with the state licensing board.

Dr. Beenthere was unprepared for the letter from the ethics committee, wondering what business it was of anyone's to say with whom he could and could not consort. He seemed to have lost touch with ethical responsibilities to his client. Dr. Vast was also incensed by the charges, claiming the complainant and the members of the licensing board were jealous of her success.

### Using Clients for Self-Gratification

Aside from viewing clients as an audience while talking about oneself, Knapp and VandeCreek (2006) described two additional types of self-gratifiers. The first, "psychological voyeurs," are therapists who elicit details about clients' lives for their entertainment value.

**Case 8–9:** Television aficionado Fan Atic, Ph.D., was delighted when Rolee Starlet, the actress who played a scrub nurse on Dr. Atic's favorite TV doctor show, became his client. After 10 sessions, Ms. Starlet complained to a licensing board that Dr. Antic was exploiting her by spending much of their time trying to draw out the behind-the-scenes gossip and hardly any time on the anxiety issues that brought her into therapy.

The second type of self-gratifier, labeled the "intrusive advocate," involves soliciting clients to support the therapist's causes.

**Case 8–10:** An avid environmentalist, Keepa Tree, L.M.F.T., encouraged clients to join her local group to save a grove of redwoods; she handed out brochures, informed them of upcoming rallies, and placed a donation jar in the waiting area. Some clients worried that Ms. Tree might find fault with them if they did not accept the material, did not show up at rallies, and did not contribute to the jar.

Despite the worthiness of a cause, it was inappropriate for Ms. Tree to muster support for her own purposes, ignoring the discomfort felt by, and pressures placed on, her clients.

### Risky Clients

Not every client can tolerate boundary crossings. Even Lazarus (1994), who advocated flexible boundaries, allowed that:

> With some clients, anything other than a formal and clearly delineated doctor–patient relationship is inadvisable and is likely to prove counterproductive. It is usually inadvisable to disregard strict boundary limits in the presence of severe psychopathology; involving passive–aggressive, histrionic, or manipulative behaviors; borderline personality features; or manifestations of suspiciousness and undue hostility. (p. 257)

Trust issues often lie at the heart of the matter. Clients seen at social service and other outpatient community agencies may become disenfranchised due to deficits in cognition, judgment, self-care, and self-protection, as well as holding little social status and power. Such clients are at greater risk for exploitation (Walker & Clark, 1999). Clients who have experienced victimization through violent attacks or abuse resulting in difficulties with trust or ambivalence also benefit from clear boundary setting, despite their frequent testing of such boundaries (Borys, 1994).

Clients who have suffered early deprivations may seek to meet their residual needs by courting favor with a nurturing therapist. Developing a therapeutic relationship can mobilize high hopes that the therapist will be able to replace or supply that which was lost. If the therapist responds as a rescuer, an inappropriate cycle becomes established, and the client will again experience the loss because a therapist never can (and should never intend to) replace a parent or the past (Borys, 1994). In this context, we gain considerable insight into the psychodynamics behind many charges of "abandonment" brought by clients tangled in multiple-role relationships with their therapists.

The technique of positive limit setting involves placing restrictions when responding to the client's request while reframing the response in a way that meets a legitimate underlying need. All therapists should master this skill. Essentially, therapists must ask themselves how their potential comments or interventions will likely benefit their client. The next two cases provide examples of positive limit setting.

**Case 8–11:** Timmy Vulnerable, age 10, was enrolled in psychotherapy with Carla Carefull, Psy.D., by a state welfare agency and the foster parents with whom Timmy had been placed following a significant physical beating by his substance-abusing mother. After several months, the agency began to plan for a reunification with the mother, who would soon graduate from a drug rehabilitation program. During a session, Timmy stated, "I thought maybe if my mom started hitting me again, I could come over to your place." Dr. Carefull replied, "You're right! You do need a plan for what to do if things get bad at home. I'm not always home, so it will be better if we figure how you could get help any time." She then informed Timmy of emergency resources and how to reach them.

Dr. Carefull was moved by Timmy's situation and his poignant analysis of her as a helper in times of crisis. She also appropriately recognized, however, that she could not meet these needs in the way the child was asking.

**Case 8–12:** Rita Repeata sought psychotherapy with Hy Pedestal, Ph.D., following a breakup with the man she had been dating for 2 months. She described a series of relationships with three different men in the past year. All followed the same pattern: casual social contacts leading to sexual intimacies by the second date and a breakup within a few weeks. Each time, Rita said she "felt like ending my life." She began her second therapy session with Dr. Pedestal by telling him how helpful the first session had been and what an exceptional therapist he was. She then got out of her chair and sat on the floor at his feet, looking up at him adoringly. When Pedestal asked what she was doing, Rita replied, "I feel more comfortable like this."

Dr. Pedestal acknowledged Rita's feelings but explained how sitting on the floor in that manner would do little to break out of the pattern for which she was seeking help. Politely, but firmly, Dr. Pedestal asked her to sit in one of the office chairs and initiated a discussion of the importance of focusing on the issues bringing her into therapy.

## ENTERING INTO BUSINESS RELATIONSHIPS WITH CLIENTS

### Becoming Business Partners

Any business partnership is vulnerable to interpersonal conflict and financial loss. In the context of such certainties, it seems astonishing that therapists have willfully undertaken risky associations with their ongoing clients. There is no such thing as "strictly business" when one of the partners has a fiduciary duty to uphold the trust and ensure the personal welfare of the other, who in turn has no such obligations. Ventures that went awry illustrate the damage done to both therapists and their clients.

**Case 8–13:** C. P. Yu had been a client of Teki Grabbit, Psy.D., for almost 2 years. Dr. Grabbit was in awe of Yu's programming skills. When Yu announced his intent to start a data management company and invited Dr. Grabbit to become an investor, she jumped at the chance. The company was formed, but things moved slowly. Yu quit therapy because, as he later stated in his complaint to a state licensing board, "During our sessions, Dr. Grabbit focused almost exclusively on the company, demanded I make certain changes in the business plan, and ignored the personal issues I needed to deal with. When I told her I resented having to pay her to talk about the business, she yelled, 'You owe it to me.'"

**Case 8–14:** "You and I would make a great team," declared cosmetic surgeon Marcel Sculpt to his counselor Barb Overhead, L.M.H.C. "My patients often need counseling, and some of your clients may be interested in my services. We could share an office suite and call ourselves, 'Beautiful Inside and Out.' I can get you clients." Ms. Overhead, whose client caseload was flagging, thought the idea a bit wacky. But, the more she considered the potential benefits, the more attracted she became. Ms. Overhead did require Sculpt to continue his therapy with someone else, figuring this would defuse any mixed-role conflicts. However, the expected clientele did not materialize, and Ms. Overhead's share of the lavish office expenses proved to be more than she could afford. Her relationship with Sculpt soured, and when they argued, she brought up content from his past counseling sessions to use against him. The partnership was dissolved, leaving Ms. Overhead in debt. Overhead blamed Sculpt for cajoling her into such a ridiculous venture and is considering suing him.

No one goes into business to lose money, which puts immediate and complicating expectations and pressures on both clients and therapists. Greed played a large role in both Grabbit's and Overhead's cases, even though neither would likely admit it. As a result, they became entangled in business dealings to the detriment of their clients' needs and ultimately to their own welfare. Both should have recognized from the outset how their objectivity and judgment could be impaired. Grabbit lost her entire investment, more than $50,000, and was further admonished by her state licensing board. Ms. Overhead believed that because Sculpt instigated the partnership and because she terminated the therapy with him, she had no responsibility for what then transpired. On the contrary, the responsibility rested exclusively with her because her training should have enabled her to foresee the potential hitch in the plan. Terminating a client for the purpose of going into business constitutes unacceptable professional practice even if Overhead did assist Sculpt in finding a new therapist. Using material shared in confidence to berate a business partner is unethical. If Overhead goes ahead with her lawsuit, she will be in for a surprise when the tables turn on her.

Whereas strict provisions apply to entering into sexual relationships with former clients (see Chapter 9), only NASW (1.06) specifies that entering any multiple-role relationships with *former* clients is unethical if there is a risk of exploitation or harm. It appears, however, that engaging in business relationships with those one formerly treated is not uncommon (Lamb et al., 1994; Pope et al., 1987). Unfortunately, these surveys did not probe how well the ventures fared.

### Professional Relationships With Employees

Some degree of relational blending occurs naturally in most work settings. Employees and

their supervisors are often friendly, care about each other's welfare, and attend some of the same social events away from the business. The workplace can also be rife with land mines—gossip, conflicts, incivility, competition for promotions and resources, and disliked coworkers—all of which contribute to the potential for volatility. Therefore, this ever-changing environment should not be further complicated by willfully appending yet another professional role to it. Employees almost always have reasonable alternatives for any needed psychotherapy services.

**Case 8–15:** Jan Typer worked as a data entry clerk and receptionist for a community mental health agency. Helmut Honcho, Ph.D., supervised her work. When Ms. Typer experienced personal problems, she asked Dr. Honcho if he would counsel her. He agreed. Ms. Typer later submitted an ethics complaint against Honcho for blocking her promotion based on assessments of her as a client instead of on her job performance.

It may prove impossible to unravel the true basis for any job-related decision in such situations. Valid or not, Ms. Typer can always interpret any unpleasant reactions to what happens on the job as linked to the therapy or vice versa. When a client also works as an employee, the consequences of a soured multiple-role relationship can be especially devastating because of the potentially adverse career and economic ramifications. Dr. Honcho should have known better than to take on Ms. Typer as a client.

**Case 8–16:** Renega Lease, M.S.W., owned an apartment building managed by Bolt Wrench, who collected the rent and performed routine repairs. Wrench and his wife asked Ms. Lease to see them for couples counseling. During the second session, Lease learned from the wife about Wrench's habitual drinking. She fired him, thus forcing him and his wife to leave their home.

Information shared in one sector of a relationship influences the entire relationship. Lease cannot be faulted for wanting sober management of her property, but she used confidential information shared in another context to the detriment of her client.

### Employing Clients

Working with people who have a variety of polished skills will inevitably lead to a temptation to consider what these clients might have to offer as employees. Moreover, clients are often financially strapped. Employing them may feel like doing a good deed. However, as with business relationships, such alliances can obliterate the professional relationship and disperse additional emotional and financial debris in their wake.

**Case 8–17:** Oscar Scatterbill, Ph.D., hired client Thomas Clerk as his personal secretary and bookkeeper. The relationship seemed to work well until Clerk asked for a raise. Dr. Scatterbill refused, saying he was already paying Clerk a good hourly wage. Clerk countered by reciting Scatterbill's monthly income and comparing it to his own. Dr. Scatterbill allegedly laughed and said, "A comparison between you and me is hardly meaningful." An insulted Clerk quit his job as well as his therapy and wrote to an ethics committee, claiming Dr. Scatterbill "exploited and dumped me."

Dr. Scatterbill should have known better than to employ an ongoing client, especially for such a sensitive position that gave a client access to confidential information. Different roles call for different protocols, and the roles of "therapist" and "boss'" require disparate and often-conflicting styles of relating. Even if the employment is specific, time limited, and feels like a win–win situation, other unforeseen complications can arise, as the next case illustrates.

**Case 8–18:** Snap Shutter needed additional work to make overdue payments on a new boat. When Shutter offered to photograph his counselor's upcoming wedding at half price, Melvin Groom, L.M.F.T., reluctantly agreed. However, the bride found the photographs inferior and argued against paying Shutter. In the meantime, Shutter increased the agreed-on fee because the

bride proved demanding, causing him extra work and expense. The matter escalated into mayhem. Shutter quit therapy, told everyone he knew in town that Groom had married a witch, and successfully sued Groom in small claims court.

Spending beyond one's means may well be an issue to explore in therapy, but the primary problem was not Groom's to solve. Groom might have politely refused Shutter's offer, perhaps indicating that wedding plans had been finalized. In the meantime, Groom's reputation in the community as a skilled person to consult for marriage counseling tanked. A therapist can always choose to alter a client's fee downward, even temporarily. However, even financial dealings with clients motivated by genuine kindness can backfire. By becoming directly involved in a client's personal misfortune, the therapist in the next case unwittingly withdrew from his role as a safe, neutral haven.

**Case 8–19:** Barney Bigheart, Ph.D., felt sympathetic when his client Bart Busted faced foreclosure on his home. Bigheart offered to loan Busted several thousand dollars to stave off the lender. Busted gratefully accepted and signed an unsecured note with a generously low interest rate. Busted's financial situation did not improve, however, and he failed to make his loan payments to Bigheart. Even though Bigheart exerted no pressure regarding the late payments, Busted expressed considerable guilt over "letting down the only person who gives a damn about me." Busted's depression deepened, and he required hospitalization.

We can hardly question Bigheart's compassion, but we can fault his professional judgment. By attempting to solve his client's problem from a domain unrelated to therapy, he destroyed Busted's refuge by also becoming his lender. Simply remaining available as Busted's compassionate therapist, and perhaps seeing him at no cost, would have better served the client's emotional well-being.

### Bartering Arrangements

There was a time when ethics codes staunchly discouraged exchanging anything other than money for professional services, citing the potential for taking advantage of clients and distortion of the professional relationship. Except for the NASW code (1.13) that provides a list of considerations, current codes have dropped strong cautionary statements, currently admonishing only that professional judgment be used regarding any clinical contraindications and potential for exploitation (APA: 6.05; AAMFT: 8.5; ACA: A.6, A.10.e, C.6).

So, why have professional organizations transformed bartering from a forbidden practice to an almost-incidental ethical matter? Perhaps because insurance coverage for mental health services has decreased, more people seeking psychotherapy may be unable to afford it. However, clients may possess skills or objects the therapist would be willing to accept in lieu of fees (M. Hill, 1999).

On the surface, allowing bartering in hard economic times seems like a win–win situation for clients who want therapy and therapists who want clients. Lawrence (2002) asserted that as cost considerations skyrocket, bartering should become prevalent, although others (e.g., Woody, 1998) argued that bartering is fraught with risks, and it is the therapist who assumes all potential liability. We acknowledge that bartering agreements can be reasonable and even a humanitarian practice toward those who seek mental health services but are uninsured and strapped for cash. Here are a few examples of positive outcomes:

> A marriage and family therapist agreed to take fresh produce as payment for three sessions with a couple who lived on a farm out of town and needed professional advice regarding the management of an elderly parent with dementia.
>
> A counselor agreed to see a client with few means who would not accept charity. The counselor offered therapy in return for the client's carpentry work on a charitable home restoration project organized by a group the counselor supported.
>
> A psychologist performed a child assessment in exchange for five small trees from the parent and owner of a struggling nursery service.

In each of these situations, mental health services and the clients' assets were limited.

Exploitation was not at issue. The services were of relatively short duration, the economic value of the exchanges was not excessive, and the clients' needs were specific and circumscribed and did not involve complex transference issues or open-ended demands. In all three cases, the chances of untoward results were minimal, although the marriage and family counselor accepting the fresh produce did confide to us that "being practically knee deep in 100 pounds of corn presented a bit of a challenge."

*Exchanging Therapy for Services*

Bartering service for service can seem like a win–win proposition. The next case suggests such an outcome, at least for now. Things could change.

**Case 8–20:** A gifted seamstress agreed to make clothes in exchange for counseling by Donatella Pravda, L.M.H.C. The client was satisfied because she needed counseling and had plenty of available time to sew. Pravda's elation was summarized by her giddy remark at a cocktail party, "I am most assuredly the best-dressed counselor in town."

This case illustrates the potential darker side of barter arrangements. Because the counselor openly acknowledged, with delight, her dual relationship at a social gathering, she apparently never considered the inherent risks of exploitation. What will happen when an outfit does not fit properly or does not meet the counselor's requirements? What if the client becomes displeased with the counseling and begins to feel like a one-woman sweatshop? What if the counselor remains so satisfied with this relationship that she creates within the client an unnecessary dependency to match her own? These "what-ifs" are not idle speculation when one considers incidents of bartering that have already gone awry.

**Case 8–21:** Kurt Court, Esq., and Leonard Dump, Ph.D., met at a mutual friend's home. Mr. Court's law practice was suffering because of what he described as "mild depression." Dr. Dump was about to embark on what promised to be a bitter divorce. Together, they hit on the idea of swapping professional services. Dr. Dump would be Mr. Court's psychotherapy client, and Mr. Court would represent Dr. Dump in his divorce. Mr. Court proved to be far more depressed than Dr. Dump anticipated. Furthermore, Court's representation of Dump was erratic, and the likelihood of a favorable outcome looked bleak. Yet, it was Mr. Court who brought ethics charges against Dr. Dump. Court charged that the therapy he received was inferior, and that Dump spent most of the time blaming him for not getting better faster.

This case illustrates not only the potential for detrimental consequences when the follow-through phase of bartering results in unhappy clients, but also the vulnerable position in which the therapist placed himself. Dr. Dump's impatience may have been appropriate under simpler circumstances. But, because of the intertwining of nonprofessional issues, Dump was perceived as retaliatory.

Charges of exploitation are heightened when the value placed on the therapist's time and skills is set at a higher rate than those of the clients. Because the therapist's hourly rate is more likely to exceed what one would pay a client, this risk is probably present in most service-for-service exchange agreements.

**Case 8–22:** Elmo Brush offered to paint his therapist's office suite in exchange for counseling Brush's teenage daughter. Paul Peelpaint, D.S.W., treated the girl for six sessions and terminated the counseling. Brush complained that his end of the bargain would have brought $1,500 in a conventional deal. Thus, it was as though he paid $250 a session for services for which Peelpaint's other full-paying clients paid only $100. Dr. Peelpaint argued that he had satisfactorily resolved the daughter's problems, and the arrangement was valid because task was traded for task, not dollar value for dollar.

When a service cannot be cost estimated in advance, trouble lies ahead. Brush's daughter might have required 50 sessions, valued at $5,000, if Dr. Peelpaint was willing to conduct

as many sessions as therapeutically necessary and had been collecting his usual fee.

**Case 8–23:** X. Ploit, Ph.D., offered an unemployed landscaper, Sod Flower, the opportunity to design and redo his grounds in return for psychotherapy. Dr. Ploit charged $100 an hour and credited Flower at a rate of $15 an hour, which meant Flower worked over 6 hours for every therapy session received. Flower complained to Dr. Ploit that the amount of time he was spending on the yard prevented him from entering into full-time employment. Dr. Ploit responded that Flower could choose to terminate therapy and return when he was able to pay the full fee. Flower felt abandoned and exploited.

Dr. Ploit's case is even more complicated and bothersome. Ploit figured the amount due for an ongoing service considerably below the going rate for a skilled landscaper. The bartering contract most likely did exacerbate the client's difficulties. In the actual case, the client successfully sued the therapist for considerable damages. If service for service had been time defined—1 hour of the client's service is exchanged for a 1-hour therapy session—charges of exploitation would be minimized.

**Case 8–24:** Notta Rembrandt proposed painting a portrait of Gig Grump, Psy.D., in exchange for psychotherapy. Dr. Grump posed, and Rembrandt received therapy on an hour-for-hour basis. On the 11th session, Grump viewed the almost-completed canvas for the first time and expressed dissatisfaction, calling it "hideous." An insulted Rembrandt insisted the portrait was superb and "captured Grump's soul." The conversation escalated into a fervent argument. Rembrandt grabbed her canvas, stomped out, and did not return. Dr. Grump sent Rembrandt a bill for 10 sessions. Rembrandt filed an ethics complaint. Grump responded that the whole setup was the client's idea, and he was not responsible for the disputed outcome.

Possible transference and countertransference issues notwithstanding, the arrangement between Rembrandt and Grump was shaky from the beginning, given the wide variability in artistic tastes. Rembrandt prevailed in her ethics complaint. Grump's attempt to fault the client was not a persuasive defense, but he did decide to withdraw the bill.

*Exchanging Therapy for Goods.*

Exchanging professional services for tangible objects may be less problematic because a fair market price can often be established by an outside, objective source. Possibly tricky non-therapy-related interactions can also be substantially reduced. However, the value of goods often depends almost entirely on what buyers are willing to pay for them. Determining the true value of some items will prove challenging, and charges of exploitation could easily arise. Therefore, we urge considerable caution when professional services are traded for objects.

**Case 8–25:** Decora Shod, M.S.W., was treating Lenny Couch, who owned a furniture import business. Ms. Shod casually mentioned that she was redecorating her home. Couch offered to let Shod select items from his warehouse at his cost if Shod would see him at a reduced rate. Mr. Couch reasoned they would both benefit because Shod would be receiving more for far less than she could in retail outlets, and Couch would also save money. In therapy, Shod increasingly confronted Couch in areas in which she felt the client behaved in a self-destructive and defensive manner. Couch reacted negatively and contacted an ethics committee, complaining that Ms. Shod attempted to lock him in to unnecessary treatment until her home was refurnished.

**Case 8–26:** When Manifold Benz, Ph.D., learned his financially strapped client's planed to sell his classic automobiles to pay outstanding therapy bills and other debts, Benz expressed an interest in one of the cars. Dr. Benz informed the client about the same model he saw at an auto show for $19,000 and offered to credit the client with 200 hours of therapy in exchange for the car. The client stood 100 hours in arrears at the time.

Ms. Shod's confrontations may have been therapeutically justified and ethically

acceptable were they not contaminated by a superimposed arrangement. Instead, she was perceived by the client as exploitative. Benz was, in fact, exploiting his client by committing him to a specific number of future therapy sessions that the client may not need. Further, we do not know if the price Benz suggested represents fair market value, and this may be difficult to determine precisely because the item was rare, possibly unique. (That Benz allowed a client to fall 100 hours in arrears creates another ethical issue, as discussed in Chapter 12.)

**Case 8–27:** Flip Channel, Ph.D., allowed Penny Pinched to pay her past due therapy bill with a television set Penny described as "near new." However, when Dr. Channel set it up in his home, the colors were faded, and the picture flickered. He told Penny that the television was not as she represented it, and she would have to take it back and figure some other method of payment. Penny angrily retorted that Dr. Channel must have broken it because it was fine when she brought it to him. When Channel insisted that the TV was defective, Penny terminated therapy and contacted an ethics committee, complaining that Channel broke both a contractual agreement and her television set.

Dr. Channel found himself in a no-win situation as a result of the television fiasco. A therapeutic relationship was also destroyed in the process. Channel could have avoided a confrontation and perhaps saved the relationship by junking the TV without mentioning anything to Ms. Pinched. But, the therapeutic alliance might have suffered anyway due to any lingering resentment that might leak out toward his client.

### *Additional Bartering Issues*

We agree with Woody (1998) that it is difficult to confidently ascertain which clients will be well suited to a nontraditional, negotiated payment system and which should be turned down, especially near the outset of the therapeutic relationship. By definition, bartering involves a negotiation process. Is a client in distress and in need of professional services in a position to barter on an equal footing with the therapist? Even therapists are attracted to a good deal, but how does this pervasive human motive play itself out in a bartering situation with clients?

When a bartering arrangement is suggested by the client, a therapist without a clearly understood "no-barter policy" can be placed in any of three uncomfortable positions. First, if a therapist is known to barter, which is probable in small communities, turning down an unwanted proposal could be experienced as a rejection. Second, must a therapist accept something unneeded or unwanted? Can you say to a client, "Well, I sometimes accept goods for services, but I'm allergic to potatoes and don't need a llama rug." Third, how does a therapist react when one bartering client refers someone who also wants to barter, but the referral clearly is not clinically suited to it? Some of these predicaments may not end up on ethics committee tables but remain sticky nonetheless, with the potential to cause the kinds of hassles therapists would certainly prefer to avoid.

Keep in mind that most professional liability insurance policies specifically *exclude* coverage involving business relationships with clients (Bennett et al., 2006; Canter, Bennett, Jones, & Nagy, 1994; Knapp, VandeCreek, et al., 2013). Liability insurance carriers may interpret bartering arrangements as business relationships and decline to defend covered therapists should bartering schemes go awry. To obscure matters even further, failure to report the monetary value of bartered services or goods constitutes tax evasion. To fully meet legal requirements (and thereby behave in an honest and ethical manner) requires detailed documentation, creating another type of interaction with the client. The therapist who declared nothing was illegal about doing therapy for free and having that client work in the therapist's dress shop for free has set up both for charges of income tax fraud and, for the therapist, labor law violations.

Those who advise against bartering arrangements as ways of protecting both clients and therapists have been accused of giving only lip service to serving the poor (Zur, 2003). Or, "affluent guilt" was suggested by Pack-Brown and Williams (2003) as a possible factor when

financially successful therapists are faced with deciding whether to accept a request for bartering. Therapists who want to assist their clients of little means may feel pressed to accept without fully assessing the implications for the clients or themselves. Thus, given the potential for glitches, actual exploitation of clients (or the appearance of it), and unsatisfactory outcomes for both parties, we recommend bartering only after reflecting on a host of considerations. These include the client's culture, financial status, personality, and profession, among others (Zur, 2007). We advise carefully considering other special arrangements (as discussed in Chapter 12) for clients who are unable to afford psychotherapy.

Finally, should mental health professionals ever be the ones to initiate bargaining in exchange for psychotherapy?

**Case 8–28:** Ron and Isabel Penny informed Tyler Quickthinker, L.M.H.C., that financial considerations meant they would have to quit counseling despite a continuing need. Quickthinker suggested Isabel, a daytime sous chef at a local restaurant, could come to Quickthinker's house every Friday night and create a nice dinner for the family. Isabel was already feeling guilty about not being home with their three small children in the evenings.

We recommend avoiding the *instigation of* a bartering plan. Mrs. Penny may find it difficult to reject Mr. Quickthinker's off-the-cuff suggestion, and she may well have feelings about cooking for her therapist's family. To the extent that clients see their therapists as the more authoritative individual in the relationship and are dependent on them for emotional support, they may feel they must accept the therapist's proposal when they would prefer to refuse (Gutheil & Brodsky, 2008).

### *Outright Purchases of Clients' Goods*

Can a therapist purchase an item outright for cash from clients? Does that not eliminate the potential negative outcomes inherent in bartering? This is not necessarily the case.

**Case 8–29:** When Gemmy Sparkle wanted to buy a house, she decided to start selling her mother's antique jewelry. She brought an exceptionally nice piece to show her therapist, Willa Buyit, M.S.W. Buyit asked how much Sparkle wanted for it, and Sparkle quoted her a price. Buyit bought the piece outright for the quoted amount, paying cash. Over a year later, and after the therapy relationship had successfully terminated, Sparkle learned that the piece was worth far more than Buyit paid for it. Sparkle called Buyit, asking for an additional $2,000. A stunned Ms. Buyit refused.

In the actual case, the client took the therapist to small claims court and told everyone how the therapist had "taken her for a ride." The client did not prevail, but the local town paper carried a brief article about the lawsuit. The therapist's client base fell, and the residual effects had not softened 2 years later. Thus, even though the therapist did not elicit the sale and paid the full asking price at the time, the ex-client's distress took its toll. Here is a similar case with a different response:

**Case 8–30:** Ima Broke was facing financial hardship and feeling desperate. She knew her therapist, Jimmy Thoughtful, Ph.D., liked Native American décor by the paintings and items displayed in his office. She thought he would be interested in purchasing for $200 a clay pot that belonged to her grandmother. Dr. Thoughtful gently turned her down for two reasons. First, the piece was likely far more valuable than Mrs. Broke realized. But, as important, Thoughtful ascertained that the pot had been lovingly cared for as it was passed along in the family, and even if it had to be sold, he should not be the one to take over an object with considerable sentimental value.

Dr. Thoughtful was able to put his own desires aside and realize that countertransference and other issues could contaminate the therapy process. Instead, he agreed to continue to see Ms. Broke at a reduced rate, offered her the name of a respected appraiser should she still need to sell the pottery elsewhere, and provided a referral to a community financial assistance service.

When clients have items to sell, there will rarely be any reason why their therapists should be the one to purchase them. Today, many ready markets exist, and objects can be offered for sale through Internet sites, reaching thousands of potential buyers at little or no cost to sellers.

If the client offers something of value that the therapist would very much like to have because of its special characteristics or uniqueness, proceed with caution. What are possible complications based on the client's issues and your relationship? What is the most the client could get for the item elsewhere? (Do not pay less.) At what juncture is the therapy process?

**Case 8–31:** Despite his client's anger issues and financial instability, Les Patriot was enamored with Danny Whittle's intricate wood carvings. He asked to purchase a large eagle and paid Whittle more than the quoted price "to be on the safe side." The therapy alliance did not hold, and Whittle contacted a licensing board with several complaints, including charges that Patriot took advantage of him by "paying almost nothing for one of my masterpieces."

Even though Dr. Patriot attempted to ensure that the purchase would not become an exploitation issue, he was remiss in not considering the patient's emotional labiality and the fact that an original and unique object cannot be securely priced.

## MULTIPLE ROLES WITH THOSE ONE ALREADY KNOWS

### Delivery of Services to Close Friends and Family Members

Mental health professionals come to expect frequent requests for advice from friends and family. Queries can range from handling a child's biting other children to convincing a proud grandmother with short-term memory loss to move into an assisted living facility. When more than factual information or casual advice is indicated, a temptation may arise to enter into professional or quasi-professional relationships with good friends or members of one's family. Therapists may believe themselves capable of providing especially good counsel because trust already exists. Furthermore, therapists may express a willingness to see these "clients" at bargain rates or at no cost whatsoever.

Despite the seeming advantages of offering formalized counseling to friends or family, such sustained relationships should be avoided. Close relations and psychotherapy exist in the context of intimacy, but the differences between the function and process of the two are striking. Successful personal relationships are free of charge, involve the satisfaction of mutual needs, are not necessarily goal directed, and aim to last indefinitely. Professional relationships, on the other hand, aim to serve only the emotional needs of the client, usually involve payment, and focus on specific therapeutic goals followed by a termination of the relationship. When these oppositional characteristics are superimposed, the potential for adverse consequences to all concerned increases.

Mental health associations caution therapists to refrain from undertaking a professional relationship if impairment of objectivity or effectiveness might result (APA: 3.05; AAMFT: 1.3, 3.4, 4.1, 4.6; ACA: C.2.g; NASW: 4.05). Responding to a frantic call from a friend in the middle of the night is something friends do for each other. Should the friend require more than temporary comforting, offer a referral. Otherwise, as the following cases illustrate, unexpected entanglements can occur, even when therapists have benevolent intentions.

**Case 8–32:** Weight-reduction specialist Stella Stern, L.M.H.C., agreed, after many requests, to work on a professional basis with her good friend Zoftig Bluto. Progress was slow, and most of Bluto's weight returned shortly after it was lost. Dr. Stern grew impatient because Bluto did not seem to be taking the program seriously. Bluto became annoyed with Dr. Stern's irritation as well as the lack of progress. Bluto expressed disappointment in Dr. Stern, whom she believed would be able to help her lose weight quickly and effortlessly.

**Case 8–33:** An intellectual assessment of 9-year-old Freddy was recommended by the boy's school.

Freddy's father, Paul Proud, asked his brother, Peter Proud, Ph.D., to perform it. The results revealed some low-performance areas and a full-scale IQ score of 93. Paul was very upset with his psychologist–brother for "not making the boy look good to the school."

**Case 8–34:** Murray X. Plode, Psy.D., accepted his sister's 17-year-old daughter as a client. During the second session, his niece revealed being sexually abused by her father, the therapist's brother-in-law. Dr. Plode stormed over to the parents' home, threatened police action in front of the entire family, and told his brother-in-law to pack his things and leave. The father, who denied ever sexually molesting his daughter and claimed the girl was a chronic liar, complained to an ethics committee that Dr. Plode had violated his rights and destroyed his life. Plode responded that this was a strictly personal matter.

Faulty expectations, mixed allegiances, role confusion, and misinterpretations of motives can lead to disappointment, anger, and sometimes a total collapse of relationships. Dr. Stern's friend could not commit to the obligations of the professional alliance but expected results anyway. Dr. Proud's brother assumed a close family member would willingly cheat. Dr. Plode was unable to separate his role as an upset uncle from his role of a therapist upholding professional decorum and utilizing established legal recourse.

In summary, therapists are free to be completely human in their friendship and family interactions and to experience all of the attendant joys and heartaches. Their skills might prove helpful by offering emotional support, information, or suggestions. When problems become more serious or require longer term attention, however, the prudent course of action is always to assist in offering competent referrals.

## Accepting Acquaintances as Clients

Another ready source of potential client contacts flows through therapists' circles of acquaintances. A member of the same athletic club or religious congregation may request professional services. Disallowing casual acquaintances to become clients would, in general, be frustrating to consumers as well as to therapists, although each request should be carefully considered (see ACA: A.6.a). This section illustrates cautions to be considered before taking on clients who base their interest in your services on the fact that they know you slightly from another context.

**Case 8–35:** Felina Breed, Ph.D., also raised pedigree cats. Many of her therapy clients were the "cat people" she met at shows. The small talk before and after treatment sessions was usually about cats. Clients also occasionally expressed interest in purchasing kittens from Dr. Breed. She agreed to sell them to her clients, which eventually came back to haunt her. When the therapy process was not proceeding as one client wished, he accused Dr. Breed of using him as a way to market her high-priced kittens. Another client became upset because Dr. Breed sold her a cat that never won a single prize. If the therapist raised "loser cats," the client assumed, trust in her therapy skills should be questioned as well.

Dr. Breed did not adequately meet her responsibility to suppress her acquaintance role while engaging in a professional role. This disconnection can usually occur without untoward consequences if the continuation of the former role does not require more than minimal energy or contact and avoids conflicts of interest. The risks and contingency plans for likely incidental run-ins with clients should be discussed during the initial session. In Dr. Breed's case, refraining from extended discussions of cats before or after the therapy session and abstaining from selling cats to any ongoing therapy client would have been appropriate.

So, what differences exist between a friend, who should *not* be accepted as a therapy client, and an acquaintance, who may become one? Making the distinction is not clear-cut because sociability patterns among therapists themselves vary considerably. Contextual issues, such as the potential for frequent interactions with the acquaintance in other settings, also require consideration.

Generally, friends are those you would call if you needed advice, who would visit you in the hospital if you became ill, who would include you as a guest at an important event in their lives, or who you would trust with sensitive information about your own private life. Acquaintances are more typically those whose interactions with you would involve little intimately personal content, who might send a get well e-mail or card if you became ill, but who you would not arrange to see socially on any regular basis.

A twist on the acquaintance peril involves dealing with solicitations for services by someone who also holds some influence or advantage over you. Examples include a request from the head of admissions of the local college to which your daughter has applied to work with his troubled son or a call for an appointment for marriage counseling from the banker who manages your personal finances. Unless alternative services are unavailable, we encourage therapists placed in awkward positions to explain the dilemma to prospective clients and offer to help find alternative resources.

### Socializing With Current Clients

Commentators on the nature of psychotherapy have referred to it as, among other things, "the purchase of friendship" (Schofield, 1964). It is precisely the *differences* between psychotherapy and friendship that account for its potential effectiveness. Friendships should ideally begin on an equal footing, with each party capable of voluntarily agreeing to the relationship.

The various complications that can arise when clients become friends are illustrated in the cases that follow. Do take note of the therapists' delayed awareness that anything was amiss, a common phenomenon that morphs into an unwelcome surprise.

**Case 8–36:** Soon after Patty Pal began counseling with Richard Chum, L.M.F.T., Patty invited Dr. Chum and his wife to spend a weekend at her family's beach house. The outing was enjoyable for all. During the next few sessions, however, Ms. Pal became more reluctant to talk about her anxieties. Dr. Chum confronted Ms. Pal with his impression that therapy seemed to be at an impasse. She broke down and admitted she had been experiencing considerable distress but feared if she revealed more, Chum might choose to quit socializing with her and her husband.

Patty Pal found herself in a double bind. As M. R. Peterson (1992) observed about boundary violations in general, the client is always faced with a conflict of interest. No matter what they do, they risk losing something.

**Case 8–37:** Jack Ace, D.S.W., and his client, King Draw, shared an affinity for poker. Ace accepted Draw's invitations to play with Draw's friends on Wednesday nights. One evening, Dr. Ace was the big winner. After that evening, Draw began to cancel appointments and stopped attending games. A puzzled Dr. Ace telephoned Draw, who admitted the therapy no longer felt quite right. He could not be specific, but after he lost several hundred dollars to his therapist, Ace seemed dangerous rather than someone to depend on for support.

These examples did not involve clients who pressed formal ethics charges against the therapists, but such cases do exist. In these instances, the clients felt exploited or abandoned.

**Case 8–38:** Will Crony, Ph.D., treated Buddy Flash for 2 years. They also invited each other to their homes. Flash gave elegant parties, often attended by influential community leaders. During one event, Flash and Dr. Crony argued over their differences regarding the upcoming mayoral race. Flash terminated therapy and contacted an ethics committee, complaining that Dr. Crony had kept him as a client for the sole purpose of capitalizing on his social status.

**Case 8–39:** Artist Raphael Baroque complained to an ethics committee that Janis Face, Ph.D., did not follow through with her commitments. Baroque had seen Dr. Face for over a year, during which time she praised his work, accompanied him to art shows, and promised to introduce him to a gallery contact. Baroque began to feel self-assured and terminated therapy, expecting that their mutual interest in his career would continue. However,

Dr. Face did not return his calls. Baroque became frantic. When contacted by an ethics committee, Dr. Face explained how she unconditionally supported her clients, but because Baroque was no longer a client her obligations to him were over.

Ethics committees found in favor of both Flash and Baroque. The therapists had intertwined their lives in ways that confused the clients. Baroque, especially, experienced harm as a result of Dr. Face's failure to grasp the potential consequences of the significant dependency she had nurtured in her client by making promises she never intended to keep once he was no longer a client.

### Relationships With Clients After Therapy Ends

Although clients and therapists typically part ways on termination, when might more intimate social friendships or other types of relationships be formed with previous clients without the danger of multiple-role complications? Conservative critics say, "Never." An ex-client may need to reenter therapy, and a clear pathway—including the beneficial effects of continuing transference—should remain open for them. Others argue against any significant nonsexual relationships with former clients, at least for some period of time following termination (Pipes, 1997).

Shifting from a unidirectional relationship with a power differential to a shared egalitarian relationship may be difficult and even disappointing, possibly even eroding the gains from psychotherapy if the ex-client discovers the therapist-as-a-real-person is not an idealized friend or business partner. The therapists who clients believed they got to know so well may not closely resemble their professional personas in a nonprofessional context.

The ethics codes of NASW (1.06) and ACA (A.6) issue warnings for establishing nonsexual relationships with former clients, whereas the APA and AAMFT codes are silent, except for the general provision that clients should never be exploited. However, if friendship or business dealings disappoint, turn sour, or cause confusion, issues coming up during therapy may resurface to raise new doubts in the clients. Should the ex-client need additional services, such as for a court appearance, records, or other forms of support, interactions would be awkward at best.

**Case 8–40:** Sue Nami, Ph.D., and her client Marsha Nullify often discussed how well they worked together and decided to become friends as soon as therapy wound down. However, after termination Nullify found Dr. Nami overbearing and controlling in casual social situations, and Nullify's other friends disliked Nami's strident demeanor. Nullify began to distance herself from the posttherapy friendship. She even suspected that she had misjudged the helpfulness of the therapy. She sought the counsel of another therapist, who encouraged her to press ethics charges against Nami.

Nullify's charges against Dr. Nami came before an ethics committee, although not exactly as Nullify expected. Incompetence could not be conclusively proven, but what became clear to both a surprised therapist and the now ex-client was the finding of a multiple-role relationship violation. The investigation revealed Nullify's active therapy status, during which Dr. Nami focused on their evolving friendship, promising a posttherapy continuation and supposed benefits, which the APA ethics code (3.05a) specifically defines as unethical (see also ACA: A.6.a; NASW: 1.06.c). Ironically, Dr. Nami herself provided these facts as her ill-fated defense, noting how well they got along and had both agreed to the friendship during therapy. This scenario also illustrates how one can never count on a new role working out as well as the first one. Nami's authoritative personality was compatible with this client in therapy but played poorly outside the office.

So, can therapists ever safely establish relationships with former clients? Survey findings revealed such relationships are less likely to be judged as unethical and occur with some regularity (S. K. Anderson & Kitchener, 1996; Salisbury & Kinnier, 1996). The view that friendships with clients are always off limits might deny opportunities for what could

become productive, satisfying, long-term friendships (Gottlieb, 1993, 1994). The next case provides one such example.

**Case 8–41:** Mountain bike enthusiast Wilber Wheel consulted Spike Speedo, Ph.D., whom he had casually met at a biking exhibition. The therapeutic relationship went well and terminated after 16 sessions. The two men found themselves in the same race a few months later and realized how much they enjoyed knowing each other on a different basis. A close friendship endured for 25 years, and Wheel delivered the eulogy at Dr. Speedo's funeral.

Whether this account represents a likely outcome holds less relevance than the necessary precautions whenever contemplating a friendship with a person who was once a client. S. K. Anderson and Kitchener (1998) provided a list of questions to consider before proceeding: "Did we come to a formal or identifiable closure to our work together? Is there a long enough time period between the termination and this new possible relationship to allow both of us to engage with new role behaviors? Can I maintain the confidentiality of the therapeutic relationship in this post-therapeutic relationship?" (p. 93). Recall that any attempt to deflect a role blending with current clients by promising or even hinting at the possibility of altering the roles after therapy termination instantly alters the nature of the current relationship.

### Accepting Clients' Referrals of Their Close Relations

It may feel tempting to relax the criteria used for accepting clients during times of declining reimbursement for psychotherapy services. Many referrals are generated through word of mouth from colleagues and current or previous clients. However, care must be taken when satisfied clients recommend you to their own close relations. The potential for conflict of interest, unauthorized passing of information shared in confidence, and compromises in the quality of professional judgment constitute ever-present risks (see NASW: 1.06).

**Case 8–42:** Dum Tweedle felt pleased with his individual therapy progress and asked Rip Divide, Ph.D., to also counsel his fiancée Dee in individual therapy. Dum eventually pressed ethics charges against Dr. Divide for contributing to a breakup, a process that began, Dum said, at the time Dee entered therapy. He contended that Dr. Divide encouraged Dee to change in ways detrimental to him and to their relationship. Dr. Divide argued that his responsibility was to facilitate growth in each party as individuals, a responsibility he felt he had upheld.

**Case 8–43:** Tuff Juggle, Psy.D., accepted Jane Amiga as a client knowing full well that she and Sandy Comrade, an ongoing client, were best friends and that aspects of the friendship were serious treatment issues for Sandy. He reasoned he could compartmentalize them, and that the women would benefit from the fact that he knew them both. One day, he slipped and shared with Sandy something Jane had told him during a private session. Jane brought ethics charges against Juggle for breach of confidentiality.

Dr. Divide ignored the invisible "third client," namely, the relationship between the engaged couple—and attempted the improbable task of treating a duo as if they were unconnected entities. Although Dr. Juggle's situation involved a less-engrossing affinity between two clients, the fact that the friendship was an issue for one of them should have provided a sufficient front-end warning. Juggle's slip of the tongue to the wrong party is an example of an ever-present pitfall when consulting people who know each other well enough to share some of the same material during their individual sessions. Even the sharpest of memories may fail under such circumstances.

We are not suggesting that accepting referrals from current clients is always inappropriate. Therapists must, however, assess as thoroughly as possible the relationship between the potential client and the referral source, the potential client and the context in which the established client and the referral know each other, and the motivations of the client to make the referral

(Shapiro & Ginzberg, 2003). If things have any potential to become sticky, we advise referring the potential client to a suitable colleague.

## EXCHANGING GIFTS AND FAVORS

Therapists often receive tangible items as expressions of appreciation or to commemorate a special event. Holidays and the termination session are other times some clients choose to bestow gifts. These exchanges can result in a positive experience for both parties (Evans, 2005; Hahn, 1998; Knox, Dubois, Smith, Hess, & Hill, 2009). However, how gifts are received requires careful forethought and application due to how they might have an impact on both treatment relationships and outcomes (Barnett & Shale, 2013; ACA: A.10).

Accepting small material tokens, such as homemade cookies or an inexpensive item, typically poses no ethical problem. Some therapists with whom we have spoken refuse any gift as a matter of principle. However, the majority of surveyed therapists believe turning down small "safe" gifts would constitute rejection or an insult to the detriment of the client, although most would turn down an expensive gift (Borys & Pope, 1989; Pope et al., 1987). There will be times when accepting certain types of gifts (e.g., a nude calendar, boxer shorts, a condom, or any other highly personal or emotionally laden item) would be inappropriate and better addressed as a therapeutic exploration with the client. At other times, the wise therapist might want to consider what meaning certain small gifts had to the client, based on the individual circumstances (e.g., purchased flowers, a key chain, a baby doll, or a family heirloom).

Gifts, as we all know, are also bestowed for reasons unrelated to appreciation. Gifts have the power to control, manipulate, or symbolize far more than the recipient may grasp. A client may give a gift in an attempt to gain favor, to ensure he or she is liked, or even to implement what Gutheil and Brodsky (2008) called "the golden fantasy," the belief that the therapist is capable of serving the client's every need. Some clients may offer gifts in an attempt to equalize power within the relationship (Knox, Hess, Williams, & Hill, 2003) or gain the therapists' favor over some other relevant individual, such as the client's spouse (Zur, 2007). When a gift is no longer a gesture of gratitude or given to mark a special event or when even a small gift raises a therapeutic issue, questions of ethics and competent professional judgment arise. Several cases demonstrate how lines can be crossed, and ethical or other adverse consequences follow.

**Case 8–44:** Wealthy Rich Porsche gave his recently licensed therapist, Grad Freshly, Ph.D., a new car for Christmas, accompanied by a card stating: "To the only man who ever helped me." Dr. Freshly was flattered and excited. He convinced himself that his services were worth the bonus because Porsche had churned through many previous therapists with disappointing results.

As a more seasoned therapist might well have predicted, Mr. Porsche soon began to find fault with Dr. Freshly and sued him for manipulating him into giving an expensive gift. Although, among professional organizations, refusing expensive gifts from clients is specifically mentioned in only the AAMFT code (3.9), we agree that a very costly item should be refused regardless of the giver's conscious motivation. Even those who can afford it may have second thoughts should the therapeutic alliance shift. Or, a valuable gift might be a power play or setup for expecting future payback.

**Case 8–45:** Phatel Attraction brought Newton Callow, Ph.D., suggestive little presents to almost every session. These included handkerchiefs hand-embroidered with tiny women in bikinis, a T-shirt imprinted "Therapists Do It in Groups," erotic poems, and a fancy bottle with a label "Chemical Making Therapists Irresistible to Clients." Ms. Attraction ultimately pressed ethics charges against Callow for abruptly terminating and abandoning her after promising he would "be there to make her better."

Discomfort and uncertainty may interfere with a therapist's ability to provide a therapeutic